MEMORIAL HOSPITAL OF BEDFORD COUNTY FOUNDATION
10455 LINCOLN HIGHWAY, EVERETT, PA 15537-7046

HEALTH PROFESSIONS SCHOLARSHIP APPLICATION

NAME____
LAST FIRST MIDDLE INITIAL

ADDRESS____

CITY ___________________ STATE ____ ZIP ______ PHONE NUMBER______________

FATHER'S NAME______________________ MOTHER'S NAME_______________________

OR SPOUSE'S NAME____

COURSE OF STUDY ____

COLLEGE OR UNIVERSITY ACCEPTED AT____

ENTRANCE DATE________________ LENGTH OF PROGRAM__________ YEARS

HIGH SCHOOL ATTENDED__________________________ YEAR OF GRADUATION__________

LIST ANY OTHER EDUCATION (SCHOOL, DATES, NUMBER OF YEARS, CREDITS/DEGREE)

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EXTRACURRICULAR ACTIVITIES____

____

LIST NAME AND DATES OF ANY CURRENT PLACE(S) OF EMPLOYMENT (Note if position is full time or part time)

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____

LIST ANY EXPERIENCE IN HEALTH RELATED ACTIVITIES___________________________

____

LIST REASON(S) FOR ENTERING THE HEALTH FIELD_______________________________

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Please have your high school and/or college send a copy of your grade transcripts.
Submit two (2) letters of recommendation from instructors and/or employers.
In order to be considered for the scholarship, the applicant must complete the income and financial aid form to verify financial need.

I certify that all information given in this application is complete and accurate to the best of my knowledge. Completion of this application does not guarantee that the applicant will receive funds.

____ _______________

SIGNATURE OF APPLICANT DATE
(Additional pages may be attached)