

Seven Rivers Medical & Educational Foundation, Inc

Application for Scholarship

(Please clearly print all information)

Date:

Student Information

|  |  |
| --- | --- |
| Item | Information |
| Name |  |
| Address |  |
| City |  |
| State |  |
| Zip Code |  |
| Date of Birth |  |
| Phone  |  |
| Do you | [ ]  Own [ ]  Rent [ ]  Live with your parents |
| Monthly mortgage/rent payment |  |
| Monthly household income |  |
| Marital status |  |
| Number of Dependents |  |
| Ages of Dependents |  |
| Level of education Completed | [ ]  High School or GED [ ] Technical School [ ] Some College [ ] College (Degree: ) [ ] Some Post-Graduate [ ]  Post-Graduate (degree: ) |
| Current Occupation |  |
| Current Employer |  |
| Length of Employment |  |
| Hours Worked per Week |  |

School Information

|  |  |
| --- | --- |
| Item | Information |
| Chosen field of study in the healthcare profession | [ ]  CNA [ ] EMT [ ]  LPN [ ] Paramedic [ ] RN [ ] Other: |
| Name of School |  |
| Address of School |  |
| Telephone number of school? |  |
| Have you been accepted | [ ]  Yes [ ]  No (If yes, please attach a copy of your acceptance letter.) |
| Expected date of graduation |  |
| Have you registered for the program/degree | [ ]  Yes [ ]  No |

Important Note: Information submitted on this application for scholarship is subject to verification. Failure to complete all information above may result in denial of your application.

The “tuition”, “books”, and “total cost” information requested below applies to each period of study.

|  |  |
| --- | --- |
| Item | Information |
| Tuition Cost | (Submit proof of tuition cost) |
| Books Cost | (estimates if actual cost unavailable) |
| Total Cost |  |
| Amount of scholarship being requested(maximum of $1,500) |  |
| Date scholarship is needed |  |
| Class begins on |  |
| The last day to pay for tuition is |  |
|  |  |

Have you or will you apply for other financial assistance?

[ ]  Yes [ ]  No

If yes please state type of assistance

|  |  |  |
| --- | --- | --- |
| Item | Date | Amount |
| [ ]  Supplemental Loan for Students (SLS) |  |  |
| [ ]  Guaranteed Student Loan (GSL) |  |  |
| [ ]  Parent Loan for Undergraduate Students (PLUS) |  |  |
| [ ]  Federal Student Aid |  |  |
| [ ]  Other scholarship (specify sources and amounts) |  |  |

Briefly, but clearly, describe YOUR FINANCIAL NEED for applying or a scholarship from the Seven Rivers Medical & Educational Foundation, Inc.:

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PERSONAL STATEMENT

Please tell us about yourself AND specifically address why you want to be in the healthcare profession. (If necessary, use additional paper and attach it to this application.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Address | City, State | Telephone # | Relationship to Applicant |
|  |  |  |  |  |
|  |  |  |  |  |

I attest that all information provided on this application is true to the best of my knowledge.

Applicant’s signature is required to submit application

|  |  |
| --- | --- |
| **Applicant’s Signature:** | **Date:** |

[ ]  I understand that checking (clicking) this box constitutes a legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document.

Important Note: Information submitted on this application for scholarship is subject to verification.

Failure to complete all information above may result in denial of your application.

Completed application must be received no later than [Date].

Return competed application to:

The Seven Rivers Medical & Educational Foundation

Bayfront Health Seven Rivers – Volunteer Services

6201 N. Suncoast Boulevard

Crystal River, FL 34428