MATAGORDA REGIONAL MEDICAL CENTER AUXILIARY
104 7TH STREET
BAY CITY, TX 77414

APPLICATION FOR EDUCATIONAL SCHOLARSHIP

Applications for educational scholarships granted by Matagorda Regional Medical Center Auxiliary are to be completed in full and submitted to the Scholarship Committee on or before the published deadline. To qualify for a scholarship, you must plan to enter an institution of higher learning to pursue a career in the medical/health-care field. Applications which are incomplete will not be considered.

DATE_____ New_____ Renewal_____

NAME:_____

DATE OF BIRTH:_____ MARITAL STATUS: S___ M___ D___

HOME ADDRESS:_____

_____

_____

E-MAIL ADDRESS (0PTIONAL)_____

HOME PHONE:_____ WORK/CELL PHONE:_____

CITIZEN OF WHAT COUNTRY?_____

SOCIAL SECURITY NUMBER_____

FIELD OF STUDY:_____

EMPLOYMENT: List last/current employer first and indicate full-time or part-time
BUSINESS NAME: TITLE/POSITION: DATES:

_____

_____

_____

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EDUCATION: List schools (secondary and above) in chronological order

SCHOOL	DATES FROM-TO	DEGREE

HONORS OR SCHOLARSHIPS RECEIVED: If monetary award, please include amount and indicate if it is a one-time or continuing award. Attach additional sheet if necessary.

FINANCIAL AID: List all student loans, pell grants, and any other sources of income

COMMUNITY INVOLVEMENT/VOLUNTEER ACTIVITIES:

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MAJOR ACCOMPLISHMENTS: **Describe your major accomplishments to date, either academically, professionally or personally.**

_____

_____

INVOLVEMENT IN CAREER-RELATED ACTIVITIES:

_____

_____

_____

ANYTHING I WOULD LIKE FOR THE COMMITTEE TO KNOW ABOUT ME:

_____

_____

_____

GRADUATING HIGH SCHOOL SENIORS, PLEASE COMPLETE:

Father's Name:_____

Address:_____

Home Phone:_____ **Cell Phone:**_____

Employed by:_____

Position:_____

Mother's Name:_____

Address:_____

Home Phone:_____ **Cell Phone:**_____

Employed by:_____

Position:_____

Number of members in your immediately family?_____

Number of family members currently in college?_____

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DISCLOSURE STATEMENT:

I HEREBY DECLARE THAT THE ABOVE INFORMATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I ALSO AGREE THAT I WILL USE THE SCHOLARSHIP FUNDS SOLELY FOR THE PURPOSE OF CONTINUING MY EDUCATION IN THE MEDICAL FIELD.

_____ **DATE** _____

APPLICANT'S SIGNATURE

PLEASE SEE SCHOLARSHIP GUIDELINES PRIOR TO SUBMITTING APPLICATION TO THE SCHOLARSHIP COMMITTEE. IF YOU HAVE QUESTIONS RELATED TO THE APPLICATION OR GUIDELINES, PLEASE CONTACT THE SCHOLARSHIP COMMITTEE AT THE ABOVE ADDRESS.

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