

MATAGORDA REGIONAL MEDICAL CENTER
104 7TH STREET, BAY CITY, TX
SCHOLARSHIP APPLICATION

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 in the United States to pursue a career in the medical/health care field. Incomplete applications will not be considered.

(Check one) New application _____ Renewal of current application _____

Name _____ Date _____

Home Address _____ Zip Code _____

Home Phone _____ Work Phone _____

Email _____

Date of Birth _____ Marital Status: S__ M__ D__ Social Security Number _____

Resides in what county _____

Citizen of what country _____

Employment (If applicable): List most current employer first and indicate full or part time

<u>Business</u>	<u>Position</u>	<u>Dates</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Applicant's Signature _____

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

Institution

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: List all your activities. Attach additional sheet if necessary

Major Accomplishments: Describe your major accomplishments to date: academically, professionally or personally.

Involvement in career-related activities: (If any)

What I would like the scholarship committee to know about me:

Graduating High School Seniors, please complete:

Father's Name _____

Address: _____

Home Phone: _____ Work/Cell Phone: _____

Employed by: _____ Position: _____

Mother's Name _____

Address: (Indicate if same) _____

Home Phone: _____ Work/Cell Phone: _____

Employed by: _____ Position: _____

Number of members in your immediate family? _____

Number of members in your immediate family currently in college? _____

Disclosure Statement:

I hereby declare that the above information is true, accurate and complete to the best of my knowledge. I agree that I will use the scholarship funds solely for the purpose of continuing my education in the medical field.

Applicant's Signature _____ Date: _____

Please see scholarship guidelines prior to submitting application to ensure you have included all required documentation. If you are applying for a renewal, we would also suggest you review the **current** guidelines in the event they may have changed. If you have questions related to the application or guidelines, please contact the scholarship committee at the above address.