Scholarship Application

Must be majoring in a health care related field **Application Deadline: April 16, 2021**

Today's Date:_____

Important: Type or Print Clearly

Student's Name: _____ Date of Birth: _____

Mailing Address: _____

Email Address: _____

Home Phone #: _____Cell Phone #: _____

High School Name: _____

Guidance Counselor's Name: _____ Phone #:_____

**Please include your academic transcript for the purpose of reviewing scholarship eligibility

Family Data:

Father employed? Yes ____ No._____ Occupation: _____

Place of employment: _____

Mother employed? Yes _____ No_____ Occupation: _____

Place of employment _____

Number of siblings and their ages: _____

Are any siblings currently attending either college or private school? Yes _____ No_____

If yes, provide name(s) of educational institution{s} _____

Education Plan:

College or School you plan to attend: _____

Intended major area of study: _____

This is a: Two _____ Three_____ Four _____ year program?

Annual cost: Tuition only: _____Room & Board: _____

Briefly describe your career/professional goals: _____

_____

_____

_____

_____

_____

_____

_____

Please describe your extra-curricular activities:

_____

_____

_____

_____

_____

_____

List and/or explain any honors or special recognition received: _____

_____

_____

_____

_____

Financial Information:

Are you employed? Yes _____ No _____ If Yes, how long? _____

Company Name: _____

Have you saved money for your education expenses? Yes _____No _____ If Yes, how much? _____

How much can your family contribute toward your expenses annually? _____

Have you applied for financial aid? Yes _____ No _____

If not, why not?_____

Have you been granted any financial aid for your education? Yes _____ No _____

If yes, please list, indicate **dollar amount** and whether it is **an annual or one-time award:**

Loans _____

BEOG _____

Scholarships_____

Work Study _____

Other _____

_____

Special Circumstances: Please indicate in this space any unusual circumstances that the scholarship committee should be aware of i.e. illness or death in the family, unemployment or seasonal employment, unexpected expenses, etc. If there are none, leave this space blank.

_____

_____

_____

_____

Please provide two letters of recommendation (one from a member of your high school faculty). Print the names and titles of the two references: 1: _____

2: _____

I certify that the information reported on this application is accurate and correct to the best of my knowledge. I hereby give (name of high school) _____ permission to release information concerning my academic history to the Friends of Nashoba Valley Medical Center Scholarship Committee for the purpose of evaluating my eligibility for a scholarship.

Student's Signature: _____Date: _____

Print Student's Name: _____

Submit this application, academic transcript, and two letters* of *recommendation* to: *Friends* of *NVMC, Scholarship Committee, 125 Center Road, Shirley, MA 01464. ***Deadline: April 16. 2021***

Note: Completing this application does not guarantee you a scholarship. You will be notified if you have been selected to receive this scholarship.

*****This scholarship will be awarded at high school graduation.**