



Scholarship Application

(Must be majoring in health care related field)

Scholarship Application Deadline: April 15, 2008

Today's Date: _____

Important: Type or Print Clearly

Student Name: _____ Date of Birth: _____

Mailing Address: _____

Email Address: _____ Home Phone Number: _____

Cell Phone Number: _____

High School: _____ Guidance Counselor: _____

Guidance Counselor's Phone Number: _____

**Please be advised that your academic transcript will be requested 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.

Cost per year: Tuition: _____

Room & Board: _____

Briefly describe your career/professional goals: _____

Please describe your extra-curricular activities in school: _____

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

Financial Information:

Are you employed? Yes _____ No _____ If Yes, employer: _____

How long have you been employed? _____

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 notified of any financial aid available for your education? Yes _____ No _____

If yes, please list: Loans _____

BEOG _____

Scholarships _____

Work Study _____

Other _____

Are these annual or one-time awards? (Explain) _____

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). List 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 Signature: _____ Date: _____

Print Student Name: _____

Submit this application and two letters of recommendation to the Friends of Nashoba Valley Medical Center Scholarship Committee, 200 Groton Ave., Ayer, MA 01432.

Note: Completing this application does not guarantee you a scholarship. Scholarships are awarded based on the specified criteria. You will be notified if you have been selected to receive this scholarship.

*****This scholarship will be awarded at high school graduation with the actual payment being issued to the recipient upon successful completion of the first semester.**