## MaineHealth Franklin Hospital Auxiliary Health Career Scholarship Application Form

NAME				
DATE OF BIRTH			Age	
MAILING ADDRESS				
TELEPHONE NUMBER				
SCHOOL NOW ATTENDING				
IF NOT A STUDENT, PRESENT	OCCUPATION?			
PRESENT OR MOST RECENT	EMPLOYER			
YOUR TOTAL ESTIMATED A	NNUAL INCOME			
SPOUSES NAME				
SPOUSES OCCUPATION	(*************************************		a later and the	المريدة والم
SPOUSE'S TOTAL ESTIMATE INCOME	D ANNUAL			
COLLEGE, SCHOOL, OR HOS	PITAL TO WHICH YO	U SEEK		
ADMISSION HAVE YOU BEEN ACCEPTED	?		<b>YES</b>	🛛 NO
IF ALREADY ENROLLED, WH	IAT YEAR ARE YOU	IN?		
WHICH HEALTH CAREER DO	YOU HOPE TO PURS	SUE		

# IF YOU ARE A MINOR (under age 18) COMPLETE THE FOLLOWING SECTION:

NAME OF FATHER, STEPFATHER, OR MALE GUARDIAN	
AGE	
OCCUPATION	
PRESENT OR MOST RECENT EMPLOYER	
TOTAL ESTIMATED ANNUAL INCOME	
NAME OF MOTHER, STEPMOTHER, OR FEMALE GUARDIAN	
AGE	
OCCUPATION	
PRESENT OR MOST RECENT EMPLOYER	
TOTAL ESTIMATED ANNUAL INCOME	

NAME(S) AGE(S)

OTHER CHILDREN IN THE FAMILY	
OTHER CHILDREN IN FAMILY IN POST SECONDARY SCHOOLS	
OTHERS DEPENDENT UPON FAMILY FOR FINANCIAL SUPPORT RELATIONSHIP TO FAMILY	

REQUIRED: Attach a recent academic transcript to this application

# PLEASE EXPLAIN ANY UNUSUAL EXPENSES IN THE RECENT PAST OR ANTICIPATED FUTURE WHICH AFFECT THE FAMILY SITUATION:

#### ESTIMATE RESOURCES AVAILABLE TO MEET YOUR EXPENSES FOR THE ACADEMIC YEAR.

PERSONAL SAVINGS	\$
AID FROM PARENTS/RELATIVES	\$
ESTIMATED COMBINED HOUSEHOLD INCOME (YOURS & SPOUSES / PARENTS)	\$
SOCIAL SECURITY BENEFITS	\$
STATE ASSISTANCE	\$
VOCATIONAL REHABILITATION	\$
OTHER FINANCIAL RESOURCES OR SCHOLARSHIPS RECEIVED OR APPLIED FOR	\$
TOTAL RESOURCES	\$
EXPECTED TUITION, ONE YEAR	\$
ROOM & BOARD, ONE YEAR	\$
OTHER EXPENSES, ONE YEAR	\$
TOTAL EXPENSES	\$

AS A SCHOLARSHIP APPLICANT, I UNDERSTAND AND AGREE THAT: (1) I SHALL REPORT TO THE SCHOLARSHIP COMMITTEE ANY CHANGES IN MY ACADEMIC OR FINANCIAL STATUS; (2) I AUTHORIZE THE MEMBERS OF THE SCHOLARSHIP COMMITTEE TO VERIFY ANY NECESSARY INFORMATION; (3) I AFFIRM THAT THE INFORMATION SUBMITTED IN THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

DATE

APPLICANT'S SIGNATURE

#### I HEREBY CERTIFY THAT THE FOREGOING INFORMATION IS CORRECT:

DATE

PARENT OR GUARDIAN'S SIGNATURE

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PLEASE WRITE A PERSONAL LETTER ON THIS PAGE, STATING THE REASONS FOR YOUR CAREER PURSUIT, AND LIST ANY VOLUNTEER WORK, SCIENCE PROJECTS, HEALTH CAREER CLUB PARTICIPATION, ETC.

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	The second se	and the second			
Street, Street					
				A REAL PROPERTY	the second second

Signature

Date

### Please complete and return by April 1 to:

Jill Gray MaineHealth Franklin Hospital 111 Franklin Health Commons Farmington, ME 04938

REQUIRED: Attach a recent academic transcript to this application