SCHOLARSHIP APPLICATION
ALICE HYDE MEDICAL CENTER AUXILIARY
MALONE, NEW YORK 12953
CONFIDENTIAL

Name of Applicant:____

Address:____

Home Phone:________________ Cell Phone:______________

High School/College:____

Will your family assist with financial expenses?_____________________

Parents' or Spouse's Names:_______________________________________

Parents' or Spouse's Employer(s)__________________________________

____

Adjusted gross family income as listed on income tax form:_____________

Ages of siblings or children who are dependent in family (excluding self)________

Will any other family member be in college next year?____________________

Applicant's employer and occupation (if applicable)______________________

____

List any volunteer or paid expenses you have had with the AHMC or any other medical facility:____

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____

College you will be, or are now, attending:__________________________________

List your major field of study:____

Have you received acceptance from the college?_________________
Or are you in academic good standing and continuing in college?_______________

What is the approximate cost of the college you plan to attend?

Tuition:________________________ Room and Board:_________________________

Have you received, or expect to receive, any scholarships or financial assistance?

______________If yes, please indicate from whom, amount and for 1 or 4 years.

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Please list two references:

Name__________________________________Phone__________________________

Address____

Name__________________________________Phone__________________________

Address____

Signature________________________________Date___________________________

The following must be included with this application:

1. **Cover letter describing financial need, reason for choosing this health care profession, career goals and current extra curricular activities.**
2. **One <u>recent</u> letter of reference, excluding any from your New Visions Health Career Teacher.**
3. **Current <u>Official</u> school or college transcript.**
4. **<u>Submit</u> by <u>May 1st</u> to person indicated on cover letter.**

Please sign:
I give the AHMC Scholarship Committee permission to access my academic and financial records of the college I am presently attending in order to process my scholarship application, if necessary.
Name/Signature/Date____