Parental Information

Parents' or Guardians' Names: _____

Address: _____

Do you live with your parents for more than two weeks a year?	☐ Yes	☐ No
Do you receive at least $600 per year in cash or kind from them?	☐ Yes	☐ No
Were you listed as an income tax exemption by your parent(s) last year?	☐ Yes	☐ No

Father's Employer _____

Business Address _____

Mother's Employer _____

Business Address _____

Parents Total Yearly Income (Gross) _____

Total number of dependents in parents' family (including self) _____

Total number of dependents in parents' family in college (including self) _____

I certify that the statements and information are true and accurate to the best of my knowledge. I understand that any false or incomplete information could result in my not being considered for this award. I also understand that my rights of privacy will not be abused and that this award is not based on sex, race, color, religion or national origin.

Signature: _____ Date: _____

ANDERSON HOSPITAL MEDICAL STAFF SCHOLARSHIP APPLICATION

Name: _____ Social Security No.: _____

Address: _____

Date of Birth: _____ Telephone Number: _____

Applicant Information

Number of dependents to applicant's family (including self) _____

Number of dependents to applicant's family in college (including self) _____

Applicant's place of employment _____

Business Address: _____ Yearly Income: _____

If currently married, spouse's name: _____

Spouse's place of employment: _____

Business Address: _____ Yearly Income: _____

Source and amount of non-taxable Income: _____

Citizenship: U.S. _____ Other: _____ High School Graduation Date: _____

Expected College Graduation Date: _____

Overall G.P.A. _____ College Major: _____

List all activities and awards you have received: _____

_____

_____

List all financial aid or scholarship assistance you have applied for, have received, or expect to receive during 2021:

_____

_____

_____

How did you hear about the Anderson Hospital Medical Staff Scholarship?

_____

_____