375 Dixmyth Avenue / Cincinnati, Ohio / 45220-2489

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# APPLICATION FOR GOOD SAMARITAN MEDICAL DENTAL SCHOLARSHIP

**2020-2021**

**SCHOLARSHIP DEADLINE FOR FALL CONSIDERATION – June 1st, 2020**

Date

**Please print**

NAME

Last First MI Former

ADDRESS:

Number and Street Email address

City State Zip Area Code/Telephone

Employee ID #: D.O.B.: SEX: (M) (F) ­­­

HIGH SCHOOL/GED: H.S. GRADUATION DATE:

Other College or University Degree (Y/N/Type) From/To GPA

## PROGRAM INFORMATION

## University/College Name:

## Program Name:

## Total Cost of Program:

Program Enrolled: ASSOC.\_\_\_\_\_\_\_ Bachelors\_\_\_\_\_\_\_ Certification\_\_\_\_\_\_\_\_

Anticipated Graduation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Year in Program: \_\_\_\_\_ (1st, 2nd, etc.) Program GPA: \_\_\_\_\_\_\_

## EMPLOYMENT INFORMATION

Are you currently employed full time? Yes No

If no, how many hours per week?

Current Department: Years/Months:

## DEPENDENT STUDENT

Father’s Name:

Occupation: Employer:

Mother’s Name:

Occupation: Employer:

## INDEPENDENT STUDENT

Number of dependent children for whom you are responsible: Ages

Married/Single (Circle) If married, is spouse currently employed? Yes No

What area of study will you be pursuing a degree/certification?

Have you previously been awarded any scholarships? Yes No

If yes, name and date of Awards

## VOLUNTEER SERVICE/ACTIVITIES

List and describe any volunteer services and/or activities in which you have been involved, include title:

**STATEMENT:** Please share with the committee why you feel you should be considered for a Scholarship by answering the following 2 questions in essay form. ***(Important - This essay is required in order to be considered. Please attach a separate document, essay must be typed using no more than 500 words per question)***

1. What strengths do you possess that will assist you in being a successful health care provider?
2. How would receiving a scholarship help you reach your educational goals?

All Applicants will be selected and reviewed by the Scholarship Committee for awards. Your submission of this Application to Good Samaritan Foundation will ensure your application is reviewed for all awards offered.

* I authorize the Good Samaritan Foundation to release all necessary information contained in this Application to those individuals required to evaluate and approve this Application for Scholarship.
* I certify that the information provided on this form is true and correct. Sign and submit this application to Good Samaritan Foundation attn. Nancy Herzog
* Should I receive a donor’s scholarship, I understand that I am expected to write a thank you note to the committee.

## Signature of Applicant Date