NASON FOUNDATION

APPLICATION FOR HEALTHCARE SERVICES PROVIDER SCHOLARSHIP

Applications and all required materials must be received at the address below:

Mail Applications to:

Nason Foundation
1616 East Pleasant Valley Blvd.
Altoona, PA 16602

Or e-mail applications to:

info@nasonfoundation.org

Scholarship Amounts:	UP TO: *
High School Graduate	$ 500
Associates	$ 1,000
Bachelors	$ 2,500
Masters (PA, NP, etc...)	$ 6,000
Doctorate	$10,000

*depending on what year in program

May be eligible to apply for a second scholarship

1. ***General Information*** Date: _____

Name _____
Last First Middle

Present Address _____

_____ Phone _____

Parents/Legal Guardians: Name(s) _____

Address _____

_____ Phone _____

E-mail _____

Are you under 18 years of age? _____ If so, please indicate age: _____

Have you ever applied for this scholarship before? If so, when? _____

2. ***Educational/Professional Information***

Have you been accepted into an approved education/training program? Yes No

If so, please provide:

Name of Institution: _____

Address: _____

Are you enrolled as a full/part time student? No Yes

What is your intended Medical Degree? _____

As of your application date, in what year are you enrolled? _____

When are you scheduled to begin classes? Date: _____

Name and Complete Addresses of Schools	Academic Major	Years Completed	Degree/ Certification	Grade Average	Date Completed
Last High School _____					
_____					
College/School/ University _____					
_____					

*NOTE: Please attach a copy of your high school/college transcript with this application.

3. ***Previous Work Experience***

Please give a complete record during the past three (3) years. Start with most recent employment. Attach sheet if additional space is necessary.

May we contact your present employer for a reference? Yes _____ No _____

4. ***Personal References***

Please do not list relatives, previous employers or anyone you have known less than one (1) year.

Name/Occupation	Street	City State Zip	Phone
Name/Occupation	Street	City State Zip	Phone
Name/Occupation	Street	City State Zip	Phone

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5. ***Awards and Recognition***

Award	Date of Award
_____	_____
_____	_____
_____	_____

6. ***Volunteer work and Community Involvement***

Name of Organization	Dates of Service
_____	_____
_____	_____
_____	_____

7. Please attach an essay explaining your career and personal goals and how this scholarship will help you achieve them.

8. Affidavit:

In filing this application, I hereby declare that my answers are true, and I understand that any misrepresentation or omission of the facts called herein will be sufficient cause to cancel this application for the Nason Foundation Healthcare Services Provider Scholarship Program. I hereby authorize the investigation by Nason Foundation of all statements contained in this application, I authorize and instruct Nason Foundation to make inquiries where-ever it deems necessary of any person or organization to verify information contained in this application.

_____ Date _____

Applicant's Signature

NASON FOUNDATION

Nason Foundation Healthcare Services Provider Scholarship

College Registrar Form

To the Registrar:

_____ has applied for a Nason Foundation Healthcare Services Provider Scholarship. Please complete this form, attach an official transcript and put it in an envelope from your school. **Seal and sign the back of the envelope and return it to the applicant.**

The applicant has a cumulative grade point average of _____ on a scale of _____.

The applicant's class rank is _____ in a class of _____.

Anticipated date of graduation: _____.

Comments:

Registrar's Name (Printed) **and Signature** _____

School Name _____

School Address _____

City _____ **State** _____ **Zip Code** _____

Phone( )_____ Fax ( )_____ Date _____