APPLICATION FOR HEALTHCARE SERVICES PROVIDER SCHOLARSHIP

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

Mail Applications to:

Nason Foundation
1330 11th Avenue
Altoona PA 16601

Or e-mail applications to:

info@nasonfoundation.org

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

Name _____
Last First Middle

Present Address _____

_____ Phone _____

Parents/Legal Guardians: Name(s) (if applicant under age 18) _____

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 yes, please provide a copy of your acceptance letter:

Name of Institution: _____

Address: _____

Are you enrolled as full time or part time student? _____

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 or college transcript with this application. If you have completed a year of college, you do not need to provide your high school transcript. Your college transcript will suffice.

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 _____

3. 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

4. ***<u>Volunteer work and Community Involvement</u>***

Name of Organization Dates of Service

_____ _____

_____ _____

_____ _____

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

6. ***<u>Affidavit:</u>***

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.

_____ _____

Applicant's Signature Date

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 _____

Anticipated date of graduation: _____

Comments:

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

School Name _____

School Address_____

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

Phone(___) _____ **Fax (___)** _____ **Date**_____