



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) _____

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



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
-----------------	--------	----------------	-------



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.

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 _____.

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 _____