GUILFORD MEDICAL AND DENTAL MANAGERS ASSOCIATION
SCHOLARSHIP APPLICATION

(Please Print or Type)

Date of Application: _____ **Referred by**: _____

Name: _____

Address: _____

Telephone: _____ **Student ID#:** _____ **DOB:** _____

Employed: (circle) Yes or No **Full Time:** Yes or No **Part Time:** Yes or No

Employer: _____
Company Name Telephone #

_____
Employer Address

Number of Dependents: _____ **Marital Status:** (circle) S M D W

Are you currently receiving financial aid? Yes or No If yes, please indicate what type of aid you are receiving below:

_____

List other scholarships: _____

Monetary Value: _____

School or Program currently attending: _____

Degree you will achieve: _____

Expected date of graduation: _____

Current Grade Point Average: _____ (attach copy of certified transcript) **Full or Part-Time** Student (circle)

Previous/Other Education: _____

Other degrees earned (if any)**:** _____

I agree, if I am awarded a scholarship by the Guilford Medical and Dental Managers, that I will complete the required course of study, and will attempt to secure employment in Guilford County. The information that I have provided in this application is truthful and accurate.

Signature of Applicant: _____ **Date**: _____

Signature of Instructor/Department Head: _____

Program/School: _____

Please provide a permanent or forwarding address if you will not be residing at the address listed above in order for us to notify recipients of their scholarships.