GUILFORD MEDICAL AND DENTAL MANAGERS ASSOCIATION
SCHOLARSHIP APPLICATION

(Please Print or Type)

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

Name: _____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Student ID#:** _____ **DOB:** _____

Email Address: _____

Employed: _____ Yes _____ No **Full-Time:** _____ Yes _____ No **Part-Time:** _____ Yes _____ No

Employer: _____
Company Name Telephone #

_____
Employer Address

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

Are you currently receiving financial aid? _____ Yes _____ No If yes, please indicate 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:** _____

Full-Time Student _____ **Part-Time** _____

Previous/Other Education: _____

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

I, certify all information is true and correct to the best of my knowledge. I understand that the full amount will not be given directly to me, but towards my enrolled institution. I agree, if I am awarded a scholarship by the Guilford Medical and Dental Managers, that I will complete the required course of study. I acknowledge that I will be responsible for any all and fees associated with obtaining certified copies of transcripts. In the event that I am awarded the scholarship, I hereby grant GMDM permission to use my photograph, name and any information submitted with application in any of its printed publications, including web-based publications, and social media.

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

Signature of Instructor/Department Head: _____