

Castle Cares Foundation

APPLICATION FOR HEALTHCARE EDUCATIONAL SCHOLARSHIP

APPLICANT INFORMATION

Name: _____ Marital Status: _____

Address:

Telephone: _____ Email Address: _____

Employer: _____ Telephone: _____

Employer Address:

SPOUSE'S INFORMATION (IF APPLICABLE)

Name: _____ Marital Status: _____

Address:

Telephone(s): _____ Email Address: _____

Employer: _____ Telephone: _____

Employer Address:

NUMBER OF DEPENDENT CHILDREN AND AGES: _____

ANNUAL HOUSEHOLD INCOME: _____

MONTHLY EXPENSES: _____

DETAILS OF NEED

Please explain why you are seeking this scholarship and what sets you apart from other candidates.

GOALS AND ASPIRATIONS

Please list your long-term educational and career goals.

COMMUNITY SERVICE

Please list any community service you have participated in.

AWARDS OR HONORS

Please list any awards and honors you have received.

LETTERS OF RECOMENDATION

Please attached at least 3 letters of recommendation to support why you are the best candidate to receive this scholarship.

ATTESTATION

I hereby acknowledge that the above information is true, accurate, and complete to the best of my knowledge.

Signature: _____

Date: _____

Print Name: _____



APPLICATION REVIEWED

Approved for: _____ Date: _____

Disapproved for: _____ Date: _____

Reviewed By

Board Member

Board Member