



# ALPENA REGIONAL MEDICAL CENTER

## Scholarship Applicant Information

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Home Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_

Parent's or Spouse's Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

High School Graduation Date \_\_\_\_\_

Name of College Currently Attending \_\_\_\_\_

Program of Study \_\_\_\_\_

Number of Credits Earned \_\_\_\_\_ Current GPA \_\_\_\_\_

Are you reimbursed by your employer for tuition? \_\_\_\_\_

Are there any unusual family or personal circumstance you feel warrant the Screening Committee's attention in considering this scholarship?

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Work experience during high school or college:

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Awards or honors you have received during high school or college:

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Why are you interested in your field of study?

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What are your plans after graduation?

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Community activities in which you've been involved during high school and college:

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Please list any scholarships, grants, and/or loans you are seeking or have been awarded.  
(List source, amount, and whether it has been granted or is pending).

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**CERTIFICATION**

I/We hereby affirm that the information on this form is true and complete to the best of my/our knowledge. I/We are aware of the conditions under which this scholarship is awarded and I/we agree to notify Alpena Regional Medical Center of any change in circumstances or any additional scholarship aid received.

\_\_\_\_\_  
*Student Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Parent/Guardian Signature* (If student is under 18)

\_\_\_\_\_  
*Date*

Please submit by June 1 to:      Alpena Regional Medical Center  
Marketing & Development Department  
1501 W. Chisholm St.  
Alpena, MI 49707