



Prosser
Memorial Health Foundation

2020 Auxiliary Healthcare Education Scholarship

Name of Applicant: _____

Name of High School Applicant is currently enrolled in: _____

Age: _____ Date of Birth: _____ Telephone Number: _____

Permanent Address: _____

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

Number of Siblings: _____ Ages: _____

Other immediate family members attending college: _____ Name of College: _____

Gross Yearly Family Income: _____

Name and Address of College You Plan to Attend: _____

Intended Major: _____

Cost of Yearly Tuition: _____

Cost of Room & Board: _____

Have You Been Employed While Attending High School? Yes No

Please List Any Work Experience You May Have: _____

Extra-Curricular Activities: _____

Honors / Awards: _____

Community Service:

Career Goals:

Is there anything we should take into consideration that is not included on this application that you wish to share with the selection committee?

GPA: _____

Rank: _____

Out of: _____ (class size)

Student Signature

Date

Parent Signature

Date

Student Counselor Signature

Date

Checklist:

Please attach the following items to this application.

1. Scholarship Application
2. Three Letters of Recommendations
 - a. Two from teachers
 - b. One community member
3. Official High School Transcript
4. Resume
5. Current picture taped to a full white sheet of paper