THE HOSPITAL AUXILIARY HEALTHCARE SCHOLARSHIP APPLICATION FORM

APPLICANT INFORMATION

Applicant name _____

Mailing address _____

City _____ State _____ Zip _____

Mobile phone _____ Home phone _____

Email address _____

Relationship to employee (self, dependent child, spouse) _____

Previous Hospital Auxiliary scholarship recipient (yes, no) _____ If yes, please list years and amounts awarded _____

HILTON HEAD REGIONAL HEALTHCARE EMPLOYEE INFORMATION

Name of employee _____

Work location _____

Department _____ Position _____

Duration of employment at Hilton Head Regional Healthcare _____

EDUCATIONAL INSTITUTION INFORMATION

Educational institution to receive scholarship _____

City _____ State _____ Zip _____

Program of study _____ Degree sought _____

Duration of program (years) _____ Years completed _____ Year of Graduation _____

GPA (if you are beginning your post-HS education, use your HS GPA) _____

Applicants are required to read the following and sign the application.

I certify that all information in this application and attachments is complete and accurate to the best of my knowledge. Permission is given to The Hospital Auxiliary and its agents to verify any information in this application and attachments. If I am awarded the scholarship, I understand that I am responsible for all tax related implications. My FAFSA information may be reviewed by The Hospital Auxiliary during the application evaluation process. I understand that this form is one of three documents required and have read the instructions for other requirements.

Signature _____ Date _____