To: Piedmont McDuffie f/k/a University Hospital McDuffie Scholarship Committee

From: Applicant's Name:_____
(Please Print or Type)

Address:_____

_____

Phone Number:_____

Enclosed is the completed Scholarship/Loan Application for the Auxiliary Scholarship.

I affirm that all information given on the completed application is true and accurate.

_____
Signature of Applicant

_____
Date

Piedmont McDuffie f/k/a University Hospital McDuffie
Thomson, Georgia 30824
(706) 595-1411

AUXILIARY SCHOLARSHIP
FOR HEALTH RELATED CAREERS

APPLICANT NUMBER:_____

I. Biographical Data

A. Name_____
Last First Middle

B. Date of Birth:_____

C. Address:_____
Street County

_____
City State Zip

D. Phone:_____/_____
Home Work

II. Family Information

A. Name:_____
Last First Middle

Relationship to Applicant:_____

B. Address:_____
Street County

_____
City State Zip

C. Employer:_____
Company Name Phone

III. Educational Data

A. Name of High School_____Year Graduated:_____

B. Location of High School:_____
City State

C. Education Beyond High School:_____
Where and When

IV. Date of Enrollment (Check One)

A. ____ will begin_____Date:_____
Name of Program

B. ____ began_____Date:_____
Name of Program

V. Work History

A. Employed at Piedmont McDuffie f/k/a University Hospital McDuffie since:_____

B. Current position at Piedmont McDuffie: _____

C. Full time_____ Part time_____

D. Other related employment:_____

_____

_____

Please have your counselor or principal complete this section and attach a copy of the student's high school transcript.

Grade Point Average:_____

ACT Score:_____ or SAT Score:_____

Counselor or Principal's Signature:_____

Please attach a copy of acceptance letter from college or university.

APPLICATION DUE DATE: APRIL 1ST