

To: Piedmont McDuffie Hospital 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 Hospital
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 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 15th