Health Care Scholarship Application

Health Care Scholarship Application		
Name (first and last):		
Address:		
City:	State:	Zip:
Phone Number:	Email:	
Currently Employed: ☐Yes ☐ No	Where:	
Are you a LHMC Employee: ☐Yes ☐ No	Date of Hire:	Dept.:
Do you have relatives employed at LHMC?		
If yes, their name:	Relationship:	Dept.:
Field of Health Care Study:		
High School:	Graduation Date:	
College (accepted or currently attending):		
College Address:		
Expected Graduation Date:	Student Number:	
Credits Completed:	GPA:	
Have you previously received a scholarship through LHFVO? ☐Yes ☐ No		
Are you eligible for the LHMC tuition reimbursement program? ☐Yes ☐ No		
Are you eligible for any other assistance? ☐Yes ☐ No		
If yes, what?		
Marital Status:	Number of Dependents:	
Spouse's Name:		
Spouse's Place of Employment:		
Applicant's Annual Income:	Spouse's Annual Income:	
For students who are claimed as a dependent, for income tax purposes you must furnish the following information to be considered.		
Name of Parents or Guardians:		
Father's Occupation:	Father's Annual Income:	

Lake Huron Foundation
Volunteer Organization

Health Care Scholarship Application

Mother's Occupation:	Mother's Annual Income:
Number of Dependents Claimed Last Calendar Year?	
Why have you chosen to pursue a career in health care? Please attach additional page if needed.	
Is there anything else you would like the review committee to know? Please attach additional page if needed.	
By signing below, I certify that the information provided in this application is accurate and if I am selected as a recipient of this scholarship, I give Lake Huron Medical Center and Foundation my permission to release my name and photo to media outlets.	
Signature:	Date:
Printed Name of Person Signing:	