



APPLICATION

ASSOCIATE DEGREES SCHOLARSHIP PROGRAMS

- Coder Specialist
- Community Scholarship
- Diagnostic Medical Sonography
- Employee Dependent
- Nuclear Medicine
- Nursing
- Radiologic Technology
- Respiratory

UPPER LEVEL SCHOLARSHIP PROGRAMS

- BSN
- RN to BSN Program (Employees Only)
- Pharmacy
- Rehabilitation _____
- Medical Laboratory

Name of Parent/Guardian _____

(This is for Employee Dependent Scholarship Only)

How did you first hear of the scholarship program? _____

Are you presently a Memorial Healthcare System employee? _____

Can you provide proof of your legal right to work in the U.S.? Yes No

APPLICANT DATA

Social Security Number _____

Name _____

Street Address _____

City/State/Zip _____

Home Telephone Number _____

Work (Emergency) Telephone Number _____

E-mail Address _____

EMPLOYMENT DATA

Current Employer _____

Street Address _____

City/State/Zip _____

Telephone Number _____

Employment Dates _____

Position _____

Supervisor _____

Previous Employer _____

Street Address _____

City/State/Zip _____

Telephone Number _____

Employment Dates _____

Position _____

Supervisor _____

EDUCATIONAL DATA

Date Starting Program _____

Anticipated Graduation Date _____

Current Grade Point Average _____

Previous School Attended/Degree Received _____



Why are you applying for this scholarship?

What factors influenced you to choose this profession?

What are your short-term and long-term goals?

What qualities do you possess that you think make a good healthcare professional?

To support my application for the scholarship program, I am authorizing that any of my school records and employment history may be verified by appropriate personnel of the Memorial Healthcare System who will retain such information in strict confidence. I also release any respondent to inquiries from all claims. All of the statements made on the application for the scholarship program are true to the best of my knowledge. I understand that any falsification of fact is sufficient grounds for my rejection as an applicant or my termination of the scholarship program.

Equal Opportunity Employer

Signature of Applicant _____ Date _____

Please remit application and accompanying requirements to:

Jacque Vitali
Scholarship Coordinator
7200 Pines Boulevard
Building 90, Room 108
Pembroke Pines, Florida 33024
Phone No.: (954) 201-8852
Fax No.: (954) 201-8040
E-mail: jvitali@broward.edu

