HOUSTON HEALTHCARE

SCHOLARSHIP APPLICATION

Audrey Cason Scholarship
Perry Hospital Auxiliary

Name:_____ Sex (circle one): M / F
Last First M.I.

Street: _____ Phone: _____

City: _____ State: _____ Zip: _____

Date of Birth: ___ / ___ / _____ Place of Birth: _____

Father's name in full: _____ Living?: _____

Present address: _____

Present occupation: _____

Mother's name in full: _____ Living?: _____

Present address: _____

Present occupation: _____

If you live with someone other than your parents, please fill in following:

_____ _____
Name Relationship

_____ _____
Address Phone Number

Schools Attended:

Name	City/State	Dates	GPA
_____	_____	_____	_____
_____	_____	_____	_____

What courses did you study in high school toward a medical career?

_____

Have you taken the SAT? _____ Scores: _____

Scholarship Application

What types of activities, clubs, and services have you participated in during your high school years? _____

_____

_____

What awards or honors have you received? _____

_____

Give the names and addresses of three adults - not relatives - who know you and who can give information about you. *(You may include teachers, counselors, employers, ministers, etc...)*

Name	Address & Phone #	Position
1: _____	_____	_____
2: _____	_____	_____
3: _____	_____	_____

Name of school you plan to attend: _____

Have you applied and been accepted? Y / N If yes, start date: _____

Course of study: _____

Length of time to complete degree: _____

Do you anticipate any complications with family or other responsibilities that could interfere with your pursuit of this degree? Y / N

If yes, please explain: _____

_____

What is your ultimate goal? _____

_____

Please complete the following: *(Use additional sheet, if needed.)*

A. Reasons for selecting this career:

B. Work experiences (include volunteer work):

C. Reasons for entering chosen school:

D. Other statements that would indicate attitude and interests in this career:

E. Have you applied for other scholarships? If so, list scholarship name(s) and whether or not you have been selected.

STUDENT'S CERTIFICATION

I declare that the information reported is true, correct and complete.

_____ _____

Signature Date

SCHOLARSHIP AGREEMENT

It is agreed that:

1. The decision of the scholarship committee's award is final;
2. Further personal and/or financial information will be provided if the committee requires it;

3. Scholarship funding is to defray the cost of all or part of tuition and will be paid directly to the college;

4. In the event that the student ceases course study in related health field, scholarship funding will no longer apply;

5. Scholarship money will be sent to the college once a confirmation from the registrar's office of the course/class schedule is received.

I have read and clearly understand the above agreement:

Student Signature	Date	Witness
Parent/Guardian Signature	Date	Witness

Note:

- ***Transcripts required*** *- Each applicant must assure that a transcript (for Junior and Senior Year) is included with package -or- mailed to the address below.*
- ***Letters of reference*** *- Applicant must also have three (3) letters of reference attached to the application.*
- ***Applications will not be accepted if any areas are incomplete.***
- ***Deadline*** *– the receipt deadline for all information is* ***March 18, 2024, by 4pm.***

You may mail or email your completed application package to:

Mail: **Perry Hospital Scholarship Committee**
Attn: Karen Simmons
Administration
Executive Secretary
1120 Morningside Drive
Perry, GA 31069

Email: **Scholarships@hhc.org**

Effective date: 1/26/24