THE

Foundation

Champlain Valley Physicians Hospital

HIGH SCHOOL HEALTHCARE SCHOLARSHIP APPLICATION FORM

APPLICANT NAME	BIRTH DATE E-MAIL
HOME ADDRESS	PHONE

HIGH SCHOOL CURRENTLY ATTENDING ______________________ GRADUATION DATE ____________

GUIDANCE COUNSELOR NAME ____

GUIDANCE COUNSELING OFFICE PHONE # ____

EDUCATIONAL INSTITUTION YOU WILL ATTEND: (LIST SCHOOL NAME & ADDRESS)

PROGRAM OF STUDY

COMMUNITY SERVICE/ORGANIZATIONS IN WHICH YOU HAVE PARTICIPATED DURING HIGH SCHOOL

HAVE YOU PARTICIPATED IN THE JUNIOR VOLUNTEER PROGRAM AT CVPH?

PLEASE LIST ANY RELATIVES WHO WORK AT CVPH?

I AM RECEIVING GRANTS/SCHOLARSHIPS FROM OTHER SOURCES: IF YES, LIST SOURCE(S) AND AMOUNT(S)

SIGNATURE OF APPLICANT	DATE
SIGNATURE OF GUIDANCE COUNSELOR	DATE

TRANSCRIPT ATTACHED

ESSAY ATTACHED (100-200 WORDS ON WHY HEALTHCARE FIELD)

RETURN COMPLETED FORM TO:

FOUNDATION OF CVPH
SCHOLARSHIP COMMITTEE
75 BEEKMAN STREET
PLATTSBURGH, NY 12901

FOR OFFICE USE ONLY:

COURSE COMPLETION VERIFICATION:

BY: ______________________ DATE: __________

CHECK #: ______________ CHECK DATE: __________

DELIVERED TO: ______________________________