LOS ALAMITOS MEDICAL CENTER AUXILIARY

Medical Scholarship Application

TO SCHOLARSHIP APPLICANTS: Before filling out this application form, please read the following:

I. ELIGIBILITY

1. Those eligible to apply

A. Students graduating from Los Alamitos, Cypress High School, or Oxford Academy who have accepted to study a health career curriculum.
B. LAMC Campus College Students, Student Volunteers or LAMC Employees who have been accepted to study a health career curriculum.
C. Students recommended by an LAMC Doctor may be accepted for a scholarship .
D. Those recommended by an LAMC Auxiliary Member, who resides in the area and who has been accepted by an accredited institution.
E. Former scholarship recipients may reapply within four year period.

2. The school to be attended need not be a California institution; however, the institution must be accredited by a regionally accredited association of schools and colleges and offer courses in the health care field.
3. In order to apply, a 3.0 GPA is necessary.
4. To be eligible, applicant must follow all specific instructions within this application.

II. PERTINENT FACTS

1. The scholarship awarded will be applied toward tuition, fees or books, and will be sent to the Financial Aid Office of the institution designated by the scholarship recipient.
2. If a recipient drops out of school while the award is in effect, funds must be returned within the school year.
3. Selection of the recipients will be announced by April 24, 2015
4. If the student does not complete the College Verification Form by December 4, 2015 the scholarship will be forfeited.

III. APPLICANT'S RESPONSIBILITIES

1. <u>Application must be made on this form.</u>
2. Application should be <u>PRINTED LEGIBLY</u>.
3. To become a candidate, mail the following forms by March 27, 2015 to:
LAMC SCHOLARSHIP COMMITTEE, P.O. BOX 533, Los Alamitos, CA 90720
INCOMPLETE OR LATE APPLICATIONS WILL NOT BE ACCEPTED.
A. Application form.
B. Official High School Transcript(need not be Spring 2015)
C. Official Proof of Acceptance from education institution you will attend.
(If received by the time you submit the Scholarship form).
D. <u>IF IN COLLEGE, ONLY OFFICIAL COLLEGE TRANSCRIPT IS NEEDED.</u>

HEALTH CAREER SCHOLARSHIP APPLICATION

Information must be printed legibly on this form. Follow directions carefully and completely.

DEADLINE: APPLICATION MUST BE RECEIVED IN THE LOS ALAMITOS MEDICAL CENTER OFFICE BY MARCH 27, 2015

PERSONAL DATA

1. Name_____ Age____ Birthdate_____
   LAST FIRST MIDDLE

   Social Security #_____

2. Current Address_____ City_____

   State_____ Zip Code_____ Phone ( )_____

3. Parent(s) and/or Guardian(s) Name_____

   Current Address_____ City_____

   State_____ Zip Code_____ Phone( )_____

EDUCATIONAL BACKGROUND

4. Name of High School or College_____

   Address_____ City_____

   State_____ Zip Code_____ Phone( )_____

5. Name of school planning to attend in fall 2015_____

6. Major_____ 7. Scholastic Standing GPA_____

ACTIVITIES

8. Hospital Volunteer Activities_____

   _____

9. Other Activities_____

   _____

10. **What are your educational and occupational goals as they relate to the health care industry? (100 words or less)**

FINANCIAL INFORMATION

1. **All information will be kept confidential.**

2. **This information must be complete or application will not be considered.**

DEPENDENT STU7DENT

Parents Name :

Father's Name_____

Father's Employer_____

Mother's Name_____

Mother's Employer_____

Total Family Income_____

Names & ages of dependent children living at home:

_____

_____

Names of children in college:_____

_____

Amount parent(s) will provide toward your education next year_____

Amount you can contribute toward your education_____

Financial aid received from other sources(list sources):

_____

Grants: _____

Special financial circumstances of which we should be aware : _____

_____

INDEPENDENT STUDENT(SELF SUPPORTING)

Single _____ **Married** _____ **Divorced** _____

Ages of dependent children _____

Other Family Members for whom you are financially responsible _____

_____

Employer _____

Monthly Income _____

Amount and sources of other monthly income. _____

Unusual financial circumstances of which we should be aware of _____

_____

I CERTIFY TO THE BEST OF MY KNOWLEDGE ALL OF THE PREVIOUS INFORMATION IS CORRECT

_____

Student's Signature **Date**

_____ _____

Father's Signature (High School only) **Mother's Signature (High School only)**

RETURN COMPLETED APPLICATION BY MARCH 27, 2015 TO:

LAMC Scholarship Committee
P. O. Box 533
Los Alamitos, CA 90720

IMPORTANT NOTE: You will be notified by mail of your acceptance or rejection

Revised: 9/8/14