ETHEL G. SWANBECK ALLIED HEALTH SCHOLARSHIP APPLICATION

TO BE FILLED OUT AND SIGNED BY THE APPLICANT:

FULL NAME ____AGE______________

HOME ADDRESS ____

CITY ____ZIP CODE ________________________

TELEPHONE NUMBER ___________________________ E-MAIL ADDRESS ______________________

SOCIAL SECURITY NUMBER ____

NAME OF HIGH SCHOOL ____

CLASS RANK ____________________________ GPA ____

WHICH COLLEGE/UNIVERSITY DO YOU PLAN TO ATTEND? __________________________________

HAVE YOU BEEN ACCEPTED BY THIS SCHOOL? ____

WHICH FIELD WILL YOU ENTER? ____

APPROXIMATE COST OF YOUR EDUCATION PER YEAR? _____________________________________

WHAT AMOUNT WILL YOUR PARENTS (GUARDIAN) PROVIDE? ______________________________

FATHER’S OCCUPATION? _______________________ MOTHER’S OCCUPATION?________________

GUARDIAN’S OCCUPATION (if applicable) ____

NUMBER OF DEPENDENT CHILDREN IN FAMILY? ___________ AGES? ________________________

OTHER SIBLINGS OR PARENT IN COLLEGE? ____
If awarded a scholarship, I agree to notify the Chairman of the GFWC/Ohio Federation of Women’s Clubs Scholarship Board of Trustees of my intention to accept or decline this scholarship by June 30.

Applicant’s Signature ____

TO BE COMPLETED BY THE SPONSORING CLUB:

The ____________________________________ Club of (city) __________________________________ in the ________District of the GFWC/Ohio Federation of Women’s Clubs endorses this applicant for a scholarship. Additional information shall be made available on request.

Club Scholarship Chairman

Name __________________________________

Address _________________________________

City _____________________Zip __________

Telephone Number _______________________

Club President

Name __________________________________

Address _________________________________

City _______________________Zip ________

Telephone Number _______________________

OMISSION OF ANY REQUIRED DOCUMENTS WILL DISQUALIFY APPLICANT.
THIS FORM MAY BE DUPLICATED.