



MEMORIAL HOSPITAL AUXILIARY

Scholarship Application

Date Submitted to Auxiliary:		Date Received by Auxiliary:	
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Applicant's Information

Last Name:	First Name:
Mailing Address:	City/State/Zip:
Phone:	Email:
Current Department:	Circle One: NEAB Hospital NEAB Clinic
Current Position:	Circle One: Full-Time Part-Time PRN
Initial Date of Hire:	
Department Director/Manager:	

Educational Institution/Program

Educational Institution/Program:
Degree you are pursuing:
Goal date to complete degree:
Current GPA: _____ Official Transcript attached: YES/NO Unofficial Transcript attached: YES/NO
Treasurers/Financial Aid Office Mailing Address/City/State/Zip:
Student ID:

Required Documents

(*only needed for first time applicants)

*Letter of Acceptance from Institution/Program	YES	NO
*2 letters of recommendation (1 must be NEA Baptist Director/Mgr./Supervisor)	YES	NO
Most recent Official Transcript w GPA	YES	NO
Course roster/schedule for upcoming semester	YES	NO
Signed Statement of Accuracy	YES	NO



STATEMENT OF ACCURACY

I hereby affirm that all stated information provided by me is correct to the best of my knowledge. I also agree that my picture may be taken and used for any purpose deemed necessary to promote the NEA Baptist Auxiliary's scholarship program. I hereby understand that if chosen as a scholarship recipient, according to the NEA Baptist Hospital Auxiliary Scholarship guidelines, I must provide evidence of enrollment/registration at the post-secondary institution of my choice before funds can be awarded. I hereby understand that I will NOT RECEIVE A REFUND on any portion of this scholarship should there be a remaining balance after tuition and student fees/charges have been paid.

Signature of scholarship applicant: _____

Date: _____