



# Scholarship Application

Please **type** or **print in ink**, answering all questions applicable to your present status.

Date: \_\_\_\_\_ SSN: \_\_\_\_\_

Name: \_\_\_\_\_

\_\_\_\_\_ *Last* *First* *Middle Initial*

Home Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ *City* *State* *Zipcode* *Phone Number*

Date of Birth: \_\_\_\_\_ Initial Application: \_\_\_\_\_ Renewal Application: \_\_\_\_\_

List all persons presently living in your home who are dependent on the total household income:

\_\_\_\_\_ Yourself \_\_\_\_\_ Spouse \_\_\_\_\_ *Name and Age*

\_\_\_\_\_ Father \_\_\_\_\_ Siblings \_\_\_\_\_ *Names and Ages*

\_\_\_\_\_ Mother \_\_\_\_\_ Children \_\_\_\_\_ *Names and Ages*

Father's Occupation: \_\_\_\_\_

\_\_\_\_\_ *Job Title* *Employer* *Location*

Current Yearly Income: \$ \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_

\_\_\_\_\_ *Job Title* *Employer* *Location*

Current Yearly Income: \$ \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_

\_\_\_\_\_ *Job Title* *Employer* *Location*

Current Yearly Income: \$ \_\_\_\_\_

Your Occupation: \_\_\_\_\_

\_\_\_\_\_ *Job Title* *Employer* *Location*

Current Yearly Income: \$ \_\_\_\_\_

How many family members will be attending college next fall? \_\_\_\_\_

I graduated from: \_\_\_\_\_ High School on: \_\_\_\_\_

CNA certification received: \_\_\_\_\_

**Examinations:** Please list all college entrance examinations you have taken to date. Attach copies of your scores/results.

College Entrance Examination(s) - SAT score: \_\_\_\_\_ ACT score: \_\_\_\_\_

Other: \_\_\_\_\_

**College/College Plans:** Please list name of school(s) and present status.

A. Name: \_\_\_\_\_

\_\_\_\_\_ Prefer to Attend    \_\_\_\_\_ Have Applied    \_\_\_\_\_ Accepted    \_\_\_\_\_ Now Attending

B. Name: \_\_\_\_\_

\_\_\_\_\_ Prefer to Attend    \_\_\_\_\_ Have Applied    \_\_\_\_\_ Accepted    \_\_\_\_\_ Now Attending

C. Name: \_\_\_\_\_

\_\_\_\_\_ Prefer to Attend    \_\_\_\_\_ Have Applied    \_\_\_\_\_ Accepted    \_\_\_\_\_ Now Attending

Course of study I'm planning to pursue/pursing: \_\_\_\_\_ Degree: \_\_\_\_\_

What is your current academic level (based on credit hours)? **COLLEGE TRANSCRIPTS REQUIRED.**

\_\_\_\_\_ Freshman    \_\_\_\_\_ Sophomore    \_\_\_\_\_ Junior    \_\_\_\_\_ Senior

Approximate number of quarters/semesters remaining before graduation:

\_\_\_\_\_ semester(s)/quarter(s) remaining

**Special Recognition:** Please list honors, awards, scholarships, honor societies, etc.

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**Activities:** Please list high school/college activities (sports, clubs, etc.) and organized outside activities including community service.

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**Work Experience:** Please describe your work activities during the past few years, at home, at school or campus or for outside employers.

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**Outside Financial Aid:** Please list any sources of outside educational financial aid (scholarships, grants, state/federal aid, etc.) for which you have applied or which you have already been granted. Please list if you are eligible for Hope Scholarship.

Already received award?	Title of Grant	\$ Amount	Renewable?
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____

Please submit a letter from your parent(s) or legal guardian(s) if you are a dependent, stating that they are aware you are applying for this scholarship, and that they agree to provide information regarding their employment, income, as well as any other information that might be deemed appropriate by the scholarship committee to evaluate your current financial need.

Briefly describe why you would like to be a health care professional:

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**References:** Three letters of reference are required. At least one should be from recent high school teacher, college teacher or work supervisor.

**Certification:** I acknowledge that any scholarship awarded is with the understanding that I will comply with the rules of the AdventHealth Gordon Foundation scholarship committee provided to me. I also understand that if I have not enrolled in an accredited school or course within 365 days of scholarship being awarded, the funds will be relinquished. I hereby certify that all statements contained herein are true and correct.

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*Signature of Applicant*

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*Date*

**Please complete this form and return it to:**

AdventHealth Gordon Foundation  
PO Box 304  
Calhoun, GA 30703

**Deadline: April 18, 2025 at 3 pm**