



**PALESTINE REGIONAL HEALTHCARE SCHOLARSHIP
APPLICATION**

NAME: _____ DATE: _____

HOME ADDRESS: _____

SOC. SEC. #: _____ TEL: _____

CURRENT SCHOOL: _____

PROGRAM:(If applicable) _____

SCHOOL ADVISOR: _____ TEL: _____
(Name, Title, and Telephone No.)

FAMILY INFORMATION:

Parent/Guardian with whom you reside: _____

Father's Name: _____ Occupation: _____

Place of Employment: _____

Mother's Name: _____ Occupation: _____

Place of Employment: _____

Pursuing an education in which health field? _____

Colleges/Universities applying to? _____

Accepted to a College/University (name)? _____

Estimated Cost of Education per Semester: \$ _____

**ON A SEPARATE PIECE OF PAPER (NOT TO EXCEED ONE PAGE) PLEASE
EXPLAIN WHY YOU SHOULD BE SELECTED TO RECEIVE A PRMC
SCHOLARSHIP, ALONG WITH YOUR INVOLVEMENT IN ANY
CIVIC/COMMUNITY ORGANIZATIONS.**