

SCHOLARSHIP

ARMC AUXILIARY SPONSORS A NEED BASED SCHOLARSHIP FOR STUDENTS ENTERING THE MEDICAL FIELD

ALAMANCE REGIONAL MEDICAL CENTER AUXILIARY
P.O. BOX 202
1240 HUFFMAN MILL ROAD
BURLINGTON, NC 27216-0202

Note: All requested material must be received by the Scholarship committee by April 17, 2017 to be considered for an award. Applicants must reapply each year to be considered for this scholarship.

(please type or print clearly)

Social Security Number _____ / _____ / _____ Telephone () _____

Name in Full _____

Permanent Address _____
Street/Box # City State Zip

Mailing Address while in school _____
Street/Box # City State Zip

Date of Birth _____ / _____ / _____ Married _____ Single _____

Number and age of dependents _____

School you will attend during scholarship year _____

School Mailing Address

Academic Classification (scholarship year) Fr. _____ Soph. _____ Jr. _____ Sr. _____

Will you be enrolled full-time? _____ If not, number of hours registered _____ . How many hours are required for full-time? _____ .

When will you graduate? _____ Degree _____

Final Education Goal: _____

High Schools attended

| Name of School | Dates Attended | from - to |
|----------------|----------------|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Date of graduation _____ Number in class _____ Rank in class _____

List any academic honors, awards, etc. you have received:

Describe your participation in extra-curricular activities, indicating year.
Example: Band 2,3 (State only major involvement). Include offices held in class or school organizations and any community activities.

What factors, if any, should be taken into consideration in evaluating your academic record?

State briefly any paid employment you have had or now have:

| Title of position | Employed by | Type of work | Dates |
|-------------------|-------------|--------------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Will you be working during the college year? Yes _____ No _____

Father's name _____ Occupation _____

Mother's name _____ Occupation _____

If married give:

Spouse's name _____ Occupation _____

_____ Date

_____ Signature of Father, Mother, or guardian

TRANSCRIPT

Request that your college or high school mail your official transcript of latest academic work by deadline specified to address shown of front page.

Submit three letters of reference from someone who is not related, such as pastor or teacher.

In summary you must:

1. Answer every question on this form.
2. Submit your letters of reference.
3. Have the official transcript of your latest academic work (high school or college) submitted by that institution no later than the specified date.
4. Need verification letter sent with school seal.

I certify that to the best of my knowledge, the information contained in this statement is correct and complete. I understand it is my responsibility to ensure all supporting documentation (official transcripts, references, etc.) is received by the Scholarship Committee by the appropriate deadline date.

Signature of student in full

Date

Scholarships are awarded without regard to applicant's race, color, sex, religion, age, etc.

Alamance Regional Medical Center Auxiliary, Inc.

Post Office Box 202
1240 Huffman Mill Road
Burlington, N.C. 27216-0202

FEBRUARY 1, 2021

RETURN COMPLETED PACKET TO:

ARMC AUXILIARY, INC.
ATTENTION: BEVERLY TAYLOR
1240 HUFFMAN MILL ROAD
P. O. BOX 309
BURLINGTON, NC 27216

PLEASE HAVE YOUR HIGH SCHOOL FILL OUT THE **TOP HALF** OF BACK PAGE (**FINANCIAL NEED VERIFICATION FORM**) AND FORWARD TO THE COLLEGE WHERE YOU HAVE BEEN **ACCEPTED**, TO FILL OUT AND RETURN TO US NO LATER THAN MONDAY, MAY 22, 2021.

BEST WISHES TO EACH OF YOU!

BEVERLY TAYLOR
SCHOLARSHIP COORDINATOR
(336) 570-2753

FINANCIAL NEED VERIFICATION FORM

ALAMANCE REGIONAL MEDICAL CENTER AUXILIARY, INC.
P. O. Box 309 12040 Huffman Mill Road
Burlington, NC 27216

The following student has applied to our organization for a need-based scholarship. Please fill out this form and return to us. The school seal will be required to authenticate this form.

Student portion: I give permission to _____ to release all information requested by the Alamance Regional Medical Center Auxiliary, Inc. to verify need for my scholarship funds.

Date: _____ Name: _____
Address: _____

College portion: _____ has been accepted as a student in our education facility. We understand this student is being considered for a need-based scholarship this current academic year.

After considering the financial information given to our school by this student, we consider her/him (circle one):

1. Eligible for need-based financial aid
2. Not eligible for need-based financial aid

Title: _____ School Seal Required: _____

Signed: _____ Date: _____