Memorial Healthcare System

Scholarship Program Application Form

Associates Degrees Scholarship Programs*

- ☐ Cardiovascular Technologist
- ☐ Employee Dependent
- ☐ Nursing

Upper Level Scholarship Programs*

- ☐ BSN
- ☐ Medical Laboratory
- ☐ Advanced Practice Registered Nurse
- ☐ Physician Assistant

APPLICANT DATA

Name: _____

Street Address: _____

City/State/Zip: _____

Home Telephone Number: _____

Work (Emergency) Telephone Number: _____

E-mail Address: _____

How did you first hear of the scholarship program? _____

Are you presently a Memorial Healthcare System employee? _____

If yes, please write your employee number: _____

Can you provide proof of your legal right to work in the U.S.? ☐ Yes ☐ No

DEPENDENT DATA

Name of Parent/Guardian: _____
(This is for Employee Dependent Scholarship Only)

Employee number of Parent/Guardian: _____

EMPLOYMENT DATA

Current Employer: _____

Street Address: _____

City/State/Zip: _____

Telephone Number: _____

Employment Dates: _____

Position: _____

Supervisor: _____

Previous Employer: _____

Street Address: _____

City/State/Zip: _____

Telephone Number: _____

Employment Dates: _____

Position: _____

Supervisor: _____

EDUCATIONAL DATA

Date Starting Program: _____

Anticipated Graduation Date: _____

Current Grade Point Average: _____

Previous School Attended/Degree Received: _____

**Disclaimer: Scholarship monies are subject to tax deductions in accordance with IRS regulations.*

Why are you applying for this scholarship?

What factors influenced you to choose this profession?

What are your short-term and long-term goals?

What qualities do you possess that you think make a good healthcare professional?

To support my application for the scholarship program, I am authorizing that any of my school records and employment history be verified by appropriate personnel of the Memorial Healthcare System who will retain such information in strict confidence, to the extent permitted by applicable law. I release Memorial Healthcare System, its board members, officers, directors, agents, and employees from any and all claims and liability for damages related to the release of my records to Memorial Healthcare System. All of the statements made on the application for the scholarship program are true to the best of my knowledge. I understand that any falsification of fact is sufficient grounds for my rejection as an applicant or my termination of the scholarship program.

Equal Opportunity Employer

Memorial Healthcare System is proud to be an equal opportunity employer committed to workplace diversity.
You may manually sign this application or sign using a Digital ID by clicking or entering the signature field. You'll be prompted to choose an existing Digital ID or you may create a new one by selecting "Configure New Digital ID" and following the prompts.

Signature of applicant: _____ Date: _____

Please remit application and accompanying requirements to:

Jacque Vitali
Scholarship Coordinator
7200 Pines Boulevard, Building 72, Room 153
Pembroke Pines, Florida 33024
Phone Number: (954) 201-8852 | Fax Number: (954) 201-8040 | E-mail: jvitali@broward.edu

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