MPMC AUXILIARY/FOUNDATION FINANCIAL AID SCHOLARSHIP PROGRAM

Personal Information (Please type or print clearly)

Last Name: _____First Name: _____

Mailing Address: _____

City: _____State: _____Zip: _____

Primary Phone: (__ __ __) -_____- _____ E-Mail Address: _____

Birth Date: ____/__ __/__ __ __ __ Age: _____ Gender: _____

MONTH DAY YEAR

Are you: Single: _____Married: _____

Do you have dependents? Yes _____ No _____If yes, how many? _____Ages: _____

Employment/Work Experience

Name of Employer (Most Recent First)	Job Title	Dates of Employment	Hours/Week

Community Service

Organization (Most Recent First)	Dates	Hours/Week

Academic Information

List High School/College/Universities Attended (Most Recent First)	Dates of Attendance	Degree/Units Earned	GPA	GPA Scale

Current Career Goal (PT, OT, RN, MSN, etc.): _____Degree:_____

Are you enrolled in or have you been accepted to a health care career or support program? Yes _____ No _____

Accredited College or University you are or will be attending: _____

Address of College/University: _____

City: _____ State: _____ Zip: _____

Will you be attending: Full Time _____ Part Time ____ Expected date of graduation: _____

Student ID at University you will be attending: _____

Financial Information

The following information is required to determine how you will fund the upcoming school year.

If your expenses are more than your income, please explain: _____

_____

List **expenses** you expect to incur for the **ENTIRE** academic year:

Expense Item	Comments	Cost
Tuition/Fees:		
Books/Supplies:		
Room/Board:		
Other Expenses:		
	Total:	

Will you be receiving financial aid? Yes _____ No _____

Please list **ALL** funding sources:

Funding Sources for Upcoming Academic School Year	Source	Amount
Applicant Contribution:		
Family Contributions:		
Grants:		
Scholarships:		
Loans:		
Other Financial Resources:		
Special Financial Circumstances to be considered:		
	Total:	

Please list **ALL** sources of income and that of **ANYONE** supporting you:

Name	Occupation	Dates of Employment	Annual Gross Income
Applicant:			
Mother:			
Father:			
Spouse:			
Other:			
		Total:	

Applicant's Certification

1. I understand that the information provided above is used for scholarship award eligibility and selection only.
2. I affirm that the information provided within is true, complete, and accurate, and that any award may be revoked without appeal if the information is found to be otherwise.
3. I am a resident of San Mateo County: Yes _____ No _____
4. I am a Mills-Peninsula Medical Center employee: Yes _____No _____
5. I have received a previous Mills-Peninsula Auxiliary and Foundation Scholarship: Yes _____No _____
    a. If yes, what year? _____and what amount? _____
6. Signature of Applicant _____ Date _____

Personal Statement:

Please explain your career goals and aspiration. Use 12p font and one page only.