

Indiana Regional Medical Center's
Clinical Laboratory Science Scholarship Application:

Name: _____ Date of Birth: _____

Permanent Home Mailing Address:

Parent or Guardian Information:

Name: _____

Address: _____

School Information:

High School Name: _____

Address: _____

Telephone: _____ Expected graduation date: _____

Do you plan on attending an accredited college or university? ___ Yes ___ No
Please list below the name and address of the school(s), that you applied to and indicated if you were accepted.

Volunteer Community Services:

Activities and Leadership (clubs, extra curricular activities)

Work Experience:

Special Recognitions or Honors:

Financial Need:

Signature of applicant

Date

Signature of Guardian

Date

GUIDANCE COUNSELOR USE ONLY

Cumulative high school GPA: _____ Class rank _____ in class of _____

Signature of counselor

Date

