Centerpoint Medical Center
Medical Staff Scholarship Application

Applicant Name: _____ College Student ID#: _____

Address: _____ City, State, Zip Code: _____

Email Address: _____ Cell Phone Number: _____

Name of High School: _____ Graduation Date: _____

7th Semester class rank: _____ in a senior class of: _____ 7th Semester Cumulative GPA: _____

ACT or SAT composite score: _____

College or University Attending: _____

Field of Study: _____ Expected Graduation Date: _____

Tuition Cost Per Year: _____ Room and Board Cost Per Year: _____

Fees Cost Per Year: _____ Books Cost Per Year: _____

Part A (To be completed by students employed at Centerpoint Medical Center):

Are you head of a household? Yes: _____ No: _____ If yes, number of dependents you claim: _____

Name of immediate supervisor at Centerpoint Medical Center: _____

Department at Centerpoint Medical Center: _____

Part B (To be completed by dependents of Centerpoint Medical Center employees):

Parent's Name: _____

Parent's Address: _____ City, State, Zip Code: _____

Parent's Email Address: _____ Parent's Phone Number: _____

Name of parent's immediate supervisor at Centerpoint Medical Center: _____

Parent's department at Centerpoint Medical Center: _____

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Include the following with your completed application form:

- Proof of acceptance to a healthcare-specific program at your college or university;
- Your most recent transcripts (high school or college);
- List of community service activities and/or employment history.

_____

Applicant Signature

Completed application form and all items listed above must be submitted to:
Centerpoint Medical Center Medical Staff Scholarship Committee
c/o Truman Heartland Community Foundation
4200 Little Blue Parkway, Suite 340
Independence, MO 64057

Application Deadline:
June 30