



Carolinan HealthCare System
Blue Ridge

**Carolinan HealthCare System Blue Ridge Volunteers Scholarship Application
2017**

Full Name: _____ Social Security #: _____

Mailing Address: _____

Telephone Number: _____ Date of Birth: _____

Cell Phone Number: _____ E-Mail Address: _____

High School and Year Graduated: _____ (Date Graduated) _____

College/University you will attend: _____

Approximate Cost: _____

Intended Major: (Must be in the Healthcare field) _____

If Applicant is employed, where and how many hours per week? _____

Complete the appropriate blanks below:

1. a. SINGLE (DEPENDENT OF PARENTS)

Parents' Names: _____

Occupations: _____

Employers' Names and Addresses: _____

List ages of brothers/sisters at home or in college: _____

b. SINGLE (NOT DEPENDENT OF PARENTS)

Occupation: _____

Employer's Name and Address: _____

2. MARRIED

Spouse's Name: _____

Occupation: _____

Employer's Name and Address: _____