LALOR FAMILY DENTAL

Patient Scholarship Fund Application

PART I: GENERAL APPLICANT INFORMATION

Name of Applicant: _____

Address of Applicant: _____

_____

If dependent child, provide parent name: _____

Telephone Number: _____

Email Address: _____

At which office are you or the dependent child a patient?

☐ Vestal ☐ Binghamton ☐ Horseheads ☐ Dinosaur Dental

High School Data:

School Name: _____

City and State: _____

Graduation Date (Month/Year): _____

Have you applied for a benefit under this program before? ☐ Yes ☐ No

Did you receive a benefit? ☐ Yes ☐ No

If yes, please list date and amount of award(s) and please provide a copy of your last transcript after receiving the award. _____

PART II: ACCREDITED INSTITUTION

Information on Post-Secondary School You Plan to Attend:

Name: _____

Address: _____

Type of Institution (4 year college or university, 2 year community college or vocational-technical school):

_____

Year in Next School Year or Graduate Study: _____

Major Course of Study (note if a health related field): _____

Cost of Tuition for Next School Year: _____

Amount and Source of Any Financial Aid or Scholarship Awards for Next School Year: _____

Expected Graduation Date: _____

Degree Sought: _____

Please attach proof of enrollment.

Part III - ESSAY

Please provide a brief statement or summary of your plans as they relate to your educational and career objectives and long-term goals (approximately 250-300 words).

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PART IV: CERTIFICATION

I understand and agree that I am expected to maintain a minimum grade point average of 2.5 on a 4.0 scale (or its equivalent) in order to be eligible to receive any future benefits.

I acknowledge that all decisions are final. I certify that I meet the eligibility requirements of the program and the information provided is complete and accurate to the best of my knowledge. If requested, I will provide additional information requested by the Plan Administrator relating to my prior school records or the Accredited Institution. Falsification of information may result in termination of any award granted.

I agree that Lalor Family Dental may use a photograph of me and any information provided on my application in its marketing materials and plan.

_____ _____

Applicant's Signature **Date**

_____ _____

Parent's Signature *(if applicable)* **Date**

Applications must filled out online or be sent to:

Attn: Lalor Scholarship 2019
311 Garfield Avenue
Endicott, NY 13760