Beacon Health System
Scholarship Application

Semester Applied: (check current semester only)

☐ Spring (Jan-May) ☐ Summer (May-Aug) ☐ Fall (Aug-Dec)

Associate #: _____ Date of Hire: _____

Name: _____

Address: _____

City/State/Zip: _____

E-mail: _____

Home Phone: _____ Work Phone: _____

Current Position: _____ Department: _____

Degree Pursued: (check immediate degree being pursued)

☐ Doctorate ☐ Masters ☐ Bachelors ☐ Associate

Program Pursued: (be specific) _____

Educational Institution: _____

COURSE TITLE	COURSE #	CR. HRS.	START DATE	END DATE
1.				
2.				
3.				
4.				
5.				

Total Credit Hours Registered: _____

Est. Tuition Expenses: _____ (current semester only)

Est. Book Fees: _____ (current semester only)

Anticipated Graduation Date: _____

I have read, understand, and will comply with all the requirements associated with the Beacon Health System Scholarship Program.

Signature: _____ Date: _____