Dr. Ben Henderson

Medical Career Advancement

Memorial Scholarship

Application

Full Name: _____ Date: _____

Address: _____ City: _____State: _____ Zip:_____

Home Phone: _____Cell Phone: _____ e-Mail: _____

Social Security Number: _____ Have you ever been convicted of a felony? ___Yes ___ No

If yes, please explain: _____

Have you applied for this scholarship previously? ___ Yes ___ No

If yes, was it under another name and if so, what name was it? _____

What is the name of the educational facility you have been accepted to attend? _____

_____

Name of Program/Degree: _____

Date program begins: _____ Will you be a full-time or part-time student? _____

Anticipated date of graduation? _____

Please include with this application:

☐ A copy of the letter of acceptance into a certified healthcare program or college

☐ Official copy of transcripts reflecting last two years of academic study, if study occurred within the last 5 years

☐ 2 Letters of recommendation:

- ☐ Professional (current manager)
- ☐ Personal

☐ A letter stating reasons for choosing the area of healthcare you are interested in as your field of study

Application Deadline: March 31

Mobridge Regional Health Care Foundation

Please mail application to:

Mobridge Regional Healthcare Foundation
PO Box 580
Mobridge SD 57601