



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, explain _____

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

If yes, was it under another name(s) and if so what name(s) 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, 2017



Please mail application to:

Mobridge Regional Healthcare Foundation
PO Box 580
Mobridge, SD 57601