



Name: _____
Last First Middle

Address: _____

Phone Number: _____ e-mail address _____

Date of Birth: _____ Dates of Residence in WV: _____

Type of degree or certificate to be pursued _____ in the field of _____

Number of months/years required for training _____

Name and address of institution to which you have been accepted: _____

Date of Enrollment: _____

Name and Address of Parent or Guardian: _____

Names of three (3) persons submitting letters or recommendation (See governing rule #4a):

Name Occupation Town State Telephone

1. _____

2. _____

3. _____

ACT COMPOSITE SCORE _____: English _____ Math _____, Reading _____, Science _____

Official ACT report must be included with application submission

Family Income:

Please check the category below which properly illustrates total family income per year:

- Under \$10,000 \$10,000 - \$20,000 \$20,000 - \$50,000 \$50,000 to \$75,000 \$75,000 and above

Number of dependent children in your family: _____

Submit application with **ALL** supporting documentation as described in the “Rules Governing the DMC/DMC Auxiliary Scholarship” to: **DEADLINE: March 10, 2017**

**Davis Medical Center Auxiliary
ATTN: Scholarship Committee
PO Box 1484
Elkins, WV 26241**