Hawthorn Medical Associates

An Affiliate of STEWARD HEALTH CARE NETWORK

Application for Hawthorn Medical Associates Scholarship

Name: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Telephone: _____ Date of Birth: _____

HIGH SCHOOL currently attending: _____

Name of Guidance Counselor: _____

SCHOOL/COLLEGE you plan to attend in the fall of 2020: _____

City: _____ State: _____

Intended major or area of study: _____

EXTRACURRICULAR ACTIVITIES

List any activities that you have participated in during high school. This may include community service, clubs, sports, etc. ***No cover letter, resume or attachments please - select the most relevant activities and list here.***

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_____

EMPLOYMENT HISTORY

List any employment during the past two years.

Employer: _____

Type of Job: _____ Dates of Employment: from _____ to _____

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Type of Job: _____ Dates of Employment: from _____ to _____

The above statements are true to the best of my knowledge. I understand all materials are confidential, remain the property of Hawthorn Medical Associates, LLC and cannot be returned. I understand that if I do not complete the application process or if my application is received after April 3, 2020, I am not eligible for consideration.

Signature: _____ Date: _____