Pershing Healthcare Foundation
PO Box 308
Lovelock, NV 89419

Application for Scholarship Assistance

Full Name: _____

Physical Address: _____

Mailing Address, if different: _____

Phone Number: _____

Email Address: _____

Required to Participate in Scholarship Program

Did you graduate from Pershing County High School? ☐ Yes ☐ No

AND/OR

Do you currently reside in Pershing County? ☐ Yes ☐ No

AND/OR

Are you a full-time employee of Pershing General Hospital? ☐ Yes ☐ No

Current Coursework and Intended Field of Study

Have you completed all prerequisite coursework in the program for which you are applying? ☐ Yes ☐ No

Have you applied and/or been accepted to your healthcare program? ☐ Yes ☐ No

What institution(s) are you applying/have you applied to for this program? _____

_____

_____

What is your current grade point average (GPA)? _____

What healthcare program are you seeking scholarship assistance to pursue?

☐ Nursing ☐ Medicine ☐ Pharmacy ☐ Social Work ☐ Dietitian ☐ Healthcare/Business Administration

☐ Allied Health ☐ Medical Assistant ☐ Other (please describe: _____)

Program Details

Total length of professional program: _____ ☐ Semesters ☐ Quarters ☐ Other (please explain)

_____

_____

Estimated tuition: $_____ per ☐ Semester ☐ Quarter ☐ Other (please explain)

_____

_____

Anticipated Start Date: _____ Anticipated Completion Date: _____

Is licensure required prior to beginning practice in the state of Nevada? ☐ Yes ☐ No

Please explain how the Pershing Healthcare Foundation's scholarship will help you to achieve your goal and how your chosen field relates to healthcare in Pershing County.

Please review the Pershing Healthcare Foundation Scholarship Program Policy. If you agree to abide by the conditions provided for in this policy, please sign acknowledgment below.

I agree to the conditions outlined in the Pershing Healthcare Foundation Scholarship Program Policy.

_____ _____

Applicant Signature Date