

NORTH CENTRAL DENTAL FOUNDATION DENTAL AUXILIARY EDUCATION SCHOLARSHIP

I hereby make application for the North Central Dental Foundation Scholarship for Dental Education Students at IUSB. I understand that this scholarship is non refundable and will be applied directly to IUSB tuition, fees, or textbooks.

I am currently enrolled in the:

_____ Expanded Function for Dental Assisting Program

_____ Dental Assisting Program

_____ Dental Hygiene Program

PERSONAL DATA

Student and Family Information:

Student's Name _____

Social Security Number _____

Current Address _____

Permanent Address _____

Telephone Number _____

Parent/Guardian's Name (if appropriate) _____

Address _____

Or

Spouse's Name (if appropriate) _____

Previous Education:

High School Attended _____

High School Graduation Date _____

Extra-curricular Activities _____

Honors or Awards _____

Colleges Attended _____

**NORTH CENTRAL DENTAL FOUNDATION DENTAL AUXILIARY
EDUCATION SCHOLARSHIP**

_____ Dates _____
_____ Dates _____
_____ Dates _____
Extra-curricular Activities _____
Honors or Awards _____

CONFIDENTIAL EMPLOYMENT AND FINANCIAL INFORMATION:

Student's Name _____

Student Information:

Current Employer _____ How Long? _____

Job Position _____ Full time _____ hours/week
Part time _____ hours/week
summers only _____ hours/week

other employment during the year _____

List any scholarships, loans, and grants you are receiving this year.

Parents Information: (If appropriate)

Father's Employer and Occupation _____

Mother's Employer and Occupation _____

is you claimed on anyone's Income Tax Return?

_____ Yes. Relationship to you?

_____ No

List the ages of other siblings living at home _____

Spouse's Information: (If appropriate)

Spouse's Employer and Occupation _____

List the ages of children living at home _____

Who is financially responsible for your education at IUSB?

I am responsible for _____ % of my education

My parents are responsible for _____ % of my education

My spouse is responsible for _____ % of my education

**NORTH CENTRAL DENTAL FOUNDATION DENTAL AUXILIARY
EDUCATION SCHOLARSHIP**

Personal Reference #1

Name _____

Occupation _____

Address _____

Daytime Telephone Number _____

Relationship to Applicant _____

Personal Reference #2

Name _____

Occupation _____

Address _____

Daytime Telephone Number _____

Relationship to Applicant _____

Please send this application to:

North Central Dental Foundation
919 East Jefferson Boulevard Suite 105
South Bend, IN 46617

**NORTH CENTRAL DENTAL FOUNDATION DENTAL AUXILIARY
EDUCATION SCHOLARSHIP**

SCHOLARSHIP ESSAY FORM
(OPTIONAL)

Please write an essay stating your personal and professional goals. Explain how receiving this scholarship would assist you in meeting these goals. This essay should be NO MORE THAN ONE PAGE. (Please type or print)

Name _____ Date _____