



Scholarship Application 2018

Name of Applicant: _____

Date of Birth: _____

Phone Number: _____ Home Cell

1. I am applying for one of two \$500 scholarships from Parker Pediatrics & Adolescents. I understand that winners will be chosen by an independent panel who do not see any identifying information.
2. I am a graduating senior and am presently, or have been, an active patient at Parker Pediatrics.
3. I plan to enroll in an institution of higher education to pursue a career in the health care field.
4. If I am chosen as a scholarship recipient, I agree to use this scholarship fund to further my education. I also agree to allow Parker Pediatrics to announce my name and use my name and photograph in such media as the local newspaper, Parker Pediatrics' website, newsletter, and/or Facebook page.

Signature of Applicant

Date

PLEASE RETURN COMPLETED FORM TO PARKER PEDIATRICS & ADOLESCENTS OFFICE

VIA MAIL, FAX (303-841-3052), OR HAND DELIVERY

<p>Do Not Write in this Area – For Office Use Only</p> <p>Applicant Identification Number</p> <p>_____</p>



**Do Not Write in this Area – For Office Use
Only**

Applicant Identification Number

Scholarship Application

Please answer the following questions. Do not use your name or other identifying information.

High School: _____ GPA: _____

College or vocational school planning to attend:

Proposed major and/or career:

School activities / community service / work experience:



**PARKER
PEDIATRICS &
ADOLESCENTS, P.C.**

Scholarship Application

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Applicant Identification Number

Statement of your future goals and plans:

(If more space is needed, continue on additional sheets)