

**MIAMI COUNTY MEDICAL SOCIETY ALLIANCE SCHOLARSHIP
APPLICATION**

Date _____

Name _____

Street _____ City _____ State ____ Zip _____

Phone _____ Email address _____

Age _____ Marital Status _____

If married, name & address of spouse _____

If unmarried, parents' name & address _____

Career choice in nursing _____

School you attend or are now attending _____

Are you officially accepted into the School of Nursing at this school and when will you complete the schooling? _____

Are you presently in school and/ or employed? Explain _____

Itemize the cost for 1 year of schooling (tuition, housing, books, etc.) _____

Other scholarships and/or financial aid you will be receiving for the next year _____

Explain your need for financial assistance _____

Signature of applicant _____

Please attach a typewritten essay describing why you should receive this award and how it will benefit your nursing education and future goals,

Please enclose a transcript of your most recent grades with this application.

**Application must be received by March 25 at: The Troy Foundation
216 W. Franklin St., Troy OH 4537**