Dr. Angela E. Grant

Memorial Scholarship Fund

2019 APPLICATION FORM

2019 Application Form	DR. ANGELA E. GRANT MEMORIAL SCHOLARSHIP AWARD

Awards are given in amounts up to $5000 and are to assist in the expenses associated with attending college. Scholarship awards are payable only to the college/university and only for the school year 2019-2020. Students who qualify must:

- have been diagnosed with any form of cancer or have an immediate family member (mother, father, sister, brother) who has been diagnosed
- graduate from high school in the spring of 2019 with a cumulative GPA of 2.8 or above on a 4.0 scale *or* continue their education as an undergraduate or graduate student in the fall of 2019.
- enter or continue their year of study at a two to five year accredited institution
- be enrolled in a full-time curriculum
- be actively pursuing an Associate, Bachelor's, or Master's degree
- if awarded, provide a photograph and agree to the use of their picture by the Dr. Angela E. Grant Memorial Scholarship Fund.

Applications must be postmarked by May 1, 2019. Additional application forms are available upon request at www.drangelagrantscholarship.org. The scholarship is not automatically renewable, but applicants may re-apply. Send additional questions or concerns to: candicelgrant@hotmail.com, or egrant789@hotmail.com.

I. (Please print)

Applicant's name

Last ______________________________________ First ____________________________ Middle ______________

Address

Street ____ Apt. # _______________________

City ____ State__________________ Zip ____________________

Phone: Home __________________________ Cell _______________________

Email address ____

Date of Birth ______________ Age _____________ U.S. Citizen? Yes ☐ No ☐

Current or intended major field of study: ____

Current or most recent school:

Name of school ____

Address ____

Contact Person or Office ____

Phone ____

Other Educational History (post high school)

Name of institution	Location (city and state)	dates enrolled	degree, if applicable
________________________	______________________________	______________	___________
________________________	______________________________	______________	___________

Cancer Diagnosis

Check one: _____ self _____ immediate family (circle: mother, father, sister, brother)

Type of cancer ___________________________________ Year diagnosed ____________________

Other Financial Aid, Scholarships or Awards Received

Please list any other financial aid, scholarships, or awards received for your educational use:

____

____

____

To the best of my knowledge, information given above is clear and sound.

Signature of Applicant ____ Date _____________________

Guardian, if student is under 18 (print) _______________________ Signature _______________________

Where did you hear about this scholarship? _______________________ ____________________________

II. **Essay**

Submit a one to two page typed and signed essay (approx. 500 words) outlining:

- reasons why you feel you should receive assistance
- special recognitions, awards you have received
- career goals
- examples of community service
- current or previous employment opportunities
- other information you feel is pertinent

III. **Personal References (must be completed by 2 persons other than family members)**

Two forms for personal references are included with this application.

IV. **Requirements**

Applicant must submit the following no later than **May 1, (postmark deadline):**

- Application Form
- Essay
- 2 completed Personal Reference forms
- Copy of acceptance letter to a college/university
- Copy of most recent transcript from high school or university
- Physician's form

Mail the above requirements to:

The Dr. Angela E. Grant Memorial Scholarship Fund • P.O. Box 84481 • Manvel, TX 77584

Recipient(s) of the scholarship will be notified by June 1.

Scholarship award will be paid directly to the Records Office at the college you will attend in the fall of 2019.

Name of College/University ____

Address ____

Physician's Form

The Dr. Angela E. Grant Memorial Scholarship Fund has been established to financially assist college students who have been diagnosed with cancer, or who have an immediate family member (mother, father, sister, brother – living or deceased) who has been diagnosed. The applicant must have been accepted at an accredited university for the fall of 2019.

A. To be completed by applicant or physician's office

(please print)

Name of Applicant ____

Address ____

____

Phone __________________________ Email ____

Applicant will attend____________________________ College/University in the fall semester of 2019.

B. To be completed and signed by physician.

(please print)

Physician's name ____

Area of Specialization ____

Office Address ____

____

Phone ____

Email ____

Please complete #1 or #2:

1. Has the student named above been diagnosed and treated with any form of cancer? ________
2. Has a member of the applicant's immediate family (mother, father, sister, brother) been diagnosed with cancer? _________

Additional notes or observations: ____

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Physician's Signature: ____ Date:_________________

For questions or concerns, please contact: candicelgrant@hotmail.com , or egrant789@hotmail.com. For additional information about Dr. Angela E. Grant or the Scholarship Fund, go to www.drangelagrantscholarship.org.

Personal Reference Form

for the Dr. Angela E. Grant Scholarship Award

P.O. Box 84481 • Pearland, TX 77584

The Dr. Angela E. Grant Scholarship is designed to financially assist college students who are cancer survivors, or who have an immediate family member who has been diagnosed. Such students must be enrolled at an accredited institution of higher learning for the fall semester, 2019.

(Please print)
Name of Student Applicant ____
Address ____
____
Phone ___________________________ Email ____
Enrolled in _______________________________ College/University in the fall semester of 2019.

To be completed by an associate of the applicant <u>other than a family member.</u>
<u>(Please print)</u>
Today's date ____________________________________
Name of person completing this form ____
How long have you known the applicant? _________________
In what capacities are you associated with him/her? (teacher, neighbor, employer, etc.) _________________
If necessary, how may we contact you? ____

Please summarize your experiences with the applicant and reasons why you feel he or she should receive a Dr. Angela E. Grant Scholarship Award.

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Your signature ____ Phone #: _______________________

For questions or concerns, please contact: candicelgrant@hotmail.com or egrant789@hotmail.com. For additional information about Dr. Angela E. Grant or the Scholarship Fund, go to www.drangelagrantscholarship.org.

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Your signature ____ phone # ________________________