



Dr. Angela E. Grant

Memorial Scholarship Fund

2021 APPLICATION FORM

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 2021-2022. 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 2021 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 2021.
- 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, 2021. Additional application forms are available upon request at [www.drangelagrantscholarship.org](http://www.drangelagrantscholarship.org). The scholarship is not automatically renewable, but applicants may re-apply. Send additional questions or concerns to: [candicegrantekpin@yahoo.com](mailto:candicegrantekpin@yahoo.com), or [egrant789@hotmail.com](mailto: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)

<u>Name of institution</u>	<u>Location (city and state)</u>	<u>dates enrolled</u>	<u>degree, if applicable</u>
_____	_____	_____	_____
_____	_____	_____	_____

**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:

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***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 84822 • 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 2021.

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 2021.*

**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 2021.

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**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:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*For questions or concerns, please contact: [candicegrantekpin@yahoo.com](mailto:candicegrantekpin@yahoo.com), or [egrant789@hotmail.com](mailto:egrant789@hotmail.com). For additional information about Dr. Angela E. Grant or the Scholarship Fund, go to [www.drangelagrantscholarship.org](http://www.drangelagrantscholarship.org).*

**Personal Reference Form**  
**for the Dr. Angela E. Grant Scholarship Award**  
**P.O. Box 84822 • 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, 2021.*

(Please print)

Name of Student Applicant \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Enrolled in \_\_\_\_\_ College/University in the fall semester of 2021.

**To be completed by an associate of the applicant other than a family member.**

(Please print)

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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your signature \_\_\_\_\_ Phone #: \_\_\_\_\_

*For questions or concerns, please contact: [candicegrantekpin@yahoo.com](mailto:candicegrantekpin@yahoo.com) or [egrant789@hotmail.com](mailto:egrant789@hotmail.com). For additional information about Dr. Angela E. Grant or the Scholarship Fund, go to [www.drangelagrantscholarship.org](http://www.drangelagrantscholarship.org).*

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\_\_\_\_\_

Your signature \_\_\_\_\_ Phone #: \_\_\_\_\_

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Your signature \_\_\_\_\_ phone # \_\_\_\_\_