Dr. Angela E. Grant

Memorial Scholarship Fund

2024 APPLICATION FORM

2024 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 2024-2025. 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 2024 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 2024.
- 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, 2024. 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: candicegrantekpin@yahoo.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:

3422 Business Center Drive, Suite 106 #1315, Pearland, 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 2024.

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 2024.

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 2024.

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 , 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

3422 Business Center Drive, Suite 106 #1315, 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, 2024.

(Please print)

Name of Student Applicant _____

Address _____

_____

Phone _____ Email _____

Enrolled in _____ College/University in the fall semester of 2024.

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.

_____

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Your signature _____ Phone #: _____

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Your signature _____ Phone #: _____

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Your signature _____ phone # _____