

JCAHPO EDUCATION AND RESEARCH FOUNDATION

2010 Scholarship Application for Assistant Programs

Application and Guidelines are available at www.icaipo.org/foundation/

PLEASE TYPE (preferred)

If printed, please use BLACK INK

APPLICANT DATA

NAME Last _____ First _____ Middle Initial _____

MAILING Number/Street _____ Apt # _____

ADDRESS City _____ State _____ Zip _____

Telephone (____) _____ E-Mail _____

PROGRAM City _____ State _____ Anticipated Completion Date _____ (Month/Year)

CITIZENSHIP U.S. _____ Canada _____ Other/Please Specify _____

RELATIVE OF ANY OF THE FOLLOWING? Director of the school Yes__ No__ Faculty members of the school Yes__ No__ Faculty members of Dept. of Ophthalmology Yes__ No__ JCAHPO Education & Research Foundation Board of Directors Yes__ No__

Please indicate special areas of interest Contact Lenses _____ Orthoptics _____ Low Vision _____ Photography _____ Glaucoma _____ Other (please specify) _____

MEMBER INFORMATION (PLEASE SPECIFY) Health Care Association, Social Service Society, Fraternity, ATPO Delta Gamma, OPS, etc. _____

EDUCATION 2-yr. Junior College (Name/Location) _____ GPA _____

(POST-SECONDARY) 4-yr. College (Name/Location) _____ GPA _____

DEGREES _____

FINANCIAL DATA

ESTIMATED RESOURCES AVAILABLE TO YOU \$ _____ from family/spouse \$ _____ from savings \$ _____ from work \$ _____ from other scholarships \$ _____ Other (describe) _____

THIS YEAR Number of dependents _____

Total Tuition for Program _____ Tuition Owed: _____

I affirm that the information provided by me in this application is true and accurate to the best of my knowledge. I understand that the submission of incorrect or fraudulent information may result in denial of my application.

Signature _____

Date _____