CentraState Healthcare System®

Sons and Daughters Scholarship Program

Type or print all information except signatures. Completeness and neatness insure your application will be reviewed properly.

Parent/CentraState Employee Information

Employee Number _____ Name _____

Applicant/Student Data

Your official notification of acceptance into a college or university must accompany this application.

Applicant/Student Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____ Telephone _____

High School Name _____ Graduation Date: Month ____ Year_____

School Address _____

City _____ State _____ Zip _____ Telephone _____

Name of post-secondary school you plan to attend. _____
Use official school names. Do not use abbreviations.

City _____ State _____

☐ Two year Associates Degree ☐ Four Year College or University

Major Course of study _____ Anticipated Date of graduation _____

I certify that I meet the basic eligibility requirements of the program as described by policy and that the information provided is complete and accurate to the best of my knowledge. If requested, I agree to give proof of information I have given on this form. Falsification of information may not only result in termination of any scholarship but also termination of employment with CentraState Healthcare System.

Applicant/Student Signature_____ Date _____

Employee Signature_____ Date _____