LOVE MEMORIAL CLINIC SCHOLARSHIP

ELIGIBILITY REQUIREMENTS

The Love Memorial Clinic Scholarships are awarded to residents from Grant and Hardy Counties who are pursuing careers in the medical field. Applicants must have proof of acceptance in an accredited college or technical school and show a need for financial aid in order to further their education.

Recipients of scholarships will be required to sign an agreement promising to use the grant to pursue a medical career. If the recipient drops out of school or the medical program, he or she agrees to repay the amount received, without interest, within one year of the date the program was dropped.

Recipients will receive one half of their scholarship in August when they return the signed afore mentioned agreement with proof of registration. The remainder of the scholarship can be obtained in January in exchange for a copy of the student's first semester grades. Copies of the second semester grades are requested, by the Board, when they are received by the student.

Applications must be returned to the clinic or to the address below by the **MAY 1** deadline in order to be considered for that year's scholarship. Application packets must include the application form, letter of need, student transcript, and letter(s) of recommendation. All materials must be complete, legible and submitted by the required date to be considered.

Love Memorial Clinic Scholarship Committee
C/O Barb Harper
112 Kuykendall Lane
Moorefield, WV 26836

Love Memorial Clinic

Scholarship Application

Name of Applicant: _____

Name of Parent(s) or Guardian: _____

Name of Spouse, if married: _____

Address of Applicant: _____

Telephone Number (Where applicant can be reached): _____

Number in Family: _____ Number of Children at Home: _____

Number of Children in School/Grade: _____

_____

Financial Aid Applications:

What College or Technical School: _____

Estimated Cost per year: _____

Major: _____

Class Standing (High School): _____

Grade Point Average: High School: _____ Post High School: _____

Did you apply for Federal Student Aid (FAFSA): _____ If so, what is the Family Contribution Number (EFC) you received: _____ If not, how much can your parents provide: _____

Did you apply for WV Higher Education Grant: _____Other Financial Aid/Scholarships: _____

Gross Family Yearly Income: _____ Indebtedness: _____
(Line 7 Form 1040 and 1040A, Line 1 EZ Form. . . IRS Forms)

Will you receive any other sources of aid such as Social Security, Veterans Benefits, Etc.?

Which Benefit(s): _____ How much per month: _____

****Please write a letter stating why you feel you need a Love Memorial Clinic Scholarship.

DUE: MAY 1, 2021 MAIL TO: LOVE MEMORIAL CLINIC, 112 KUYKENDALL LANE, MOOREFIELD, WV 26836

Applicant's Signature and Date

Parent(s)-Guardian-Spouse Signature and Date