AMERICAN LEGION AUXILIARY
DEPARTMENT OF TEXAS
MEDICAL SCHOLARSHIP APPLICATION
PAST PRESIDENT'S PARLEY

TO BE USED IF APPLICANT IS NOT DEPENDENT ON PARENTS

Full name of Applicant _____

Mailing Address _____

City/State/Zip _____

Telephone Number ( ) _____Date of Birth _____

Social Security Number _____ Applicant's Major: _____

Has applicant received a medical scholarship previously from Past Presidents Parley? _____

If yes, when was scholarship received? _____ Occupation _____

Monthly Income _____

Application for Scholarship is being made on War Service of: {Circle one}

Father Mother Self Grandfather Grandmother Great Grandfather Great Grandmother

Name of Veteran if different from applicant _____

Living _____ Deceased _____

Date entered Active Service _____Discharge Date _____

Type of Separation or Discharge _____

Date of Birth _____ (If Deceased) _____

Marital Status: Married _____ Divorced _____ Widowed _____Single _____

Record of Spouse: _____

Address: _____

Occupation _____ Monthly Income _____

If a Veteran, give dates of service _____

If spouse is deceased, date of death _____

Number of children in family: Under 18 years of age _____ Over 18 years of age _____

Number of Dependents in the home other than immediate family: _____

Date of High School graduation _____Grade average last four years _____

Name and location of High School _____

_____ _____

Name and location, including exact mailing address of College or University applicant plans to attend or is currently attending. _____

_____

College grade average last year _____

Signature of Applicant _____Date _____

NOTE TO APPLICANT:

Scholarships are valid for 12 months of issued date. Checks not cashed are null and void and not replaceable.

PLEASE BE SURE TO ATTACH ALL REQUIRED MATERIALS TO THIS APPLICATION AND SUBMIT TO THE AMERICAN LEGION AUXILIARY UNIT IN THE COMMUNIITY IN WHICH YOU RESIDE FOR UNIT SIGNATURES.

To be completed by sponsoring American Legion Auxiliary Unit President or Unit Scholarship Chairman.

Name of Unit _____Unit Number _____

Mailing Address _____

District _____ Division _____

Unit's Recommendation: _____

_____ _____

_____ _____

_____ _____

_____ _____

_____

Signature of Unit President or Unit Scholarship Chairman _____ Date ___

_____

Application packet must be received NO LATER than **May 1, 2019**

Mail Medical Scholarship applications to: Gayle Simpson, PPP Chairman
P. O. Box 657, Crowell, TX 79227