Lebanon Community Hospital Foundation
John and Carol Dinges Medical Scholarship
Application

Name of applicant: _____

Address: _____

_____

Contact phone number: _____

Email address: _____

Name of high school attended: _____

Did you graduate: _____ Date of graduation or GED: _____

Date that you plan to attend LBCC: _____

Area of study: _____

Certification or degree anticipated: _____

Date of expected completion: _____

Will you be living with your parents while attending LBCC? _____

Which of the following resources will be available to you while attending LBCC?

_____Job Income _____Help from parents, spouse or relative
_____Public Assistance _____VA or Social Security Benefits
_____Financial aid (other scholarships, grants, Work Study, Pell, SEOG, etc.)

I understand that by applying for a scholarship, I give the Lebanon Community Hospital Foundation and the John and Carol Dinges Scholarship Committee permission to receive and review my transcripts.

Signature: _____ Date:_____

Established May 2010