LANCASTER COUNTY MEDICAL SOCIETY

Scholarship Request **Date:**

Applicant Information

Full Name: _____ DOB: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Employer: _____

Program of study in Healthcare: Medical Assistant, LPN, RN, or other: _____

Have you applied for other grants or assistance? YES ☐ NO ☐

Are you currently in your healthcare program? YES ☐ NO ☐

If no, do you start in the upcoming term? YES ☐ NO ☐
(Please note we only award scholarships for those in their program or starting in the upcoming term.)

Please include with this request a note of reference from a current employer or teacher.

**We ask that all applicants are entering or in their chosen healthcare program and intend to work in Lincoln for 2 years following graduation. **

Submit this application along with reference by email to admin@lcmsne.org
Or mail to LCMS 8230 Beechwood Drive Lincoln NE 68510
Call 402-483-4800 with any questions.

For office use only

Date application received: _____
Approved: _____ Denied: _____
Total approved: _____
Amount paid: _____ Date: _____ Check #: _____
Amount paid: _____ Date: _____ Check #: _____
Amount paid: _____ Date: _____ Check #: _____