SEVEN OAKS
GENERAL HOSPITAL

2018 BURSARY APPLICATION

PLEASE IDENTIFY THE BURSARY YOU ARE APPLYING FOR:

- **Gudmundur Myrdal**
- **SOGH Health Promotion & Wellness**
- **Ken Seaford**

All information herein is considered strictly confidential.
Completed applications must be submitted to Seven Oaks General Hospital Education Department by Friday, April 27th, 2018
Late, incomplete or applications submitted via email will not be accepted.

GENERAL INFORMATION (PLEASE PRINT)

NAME_____
Surname *Given Name(s)*

ADRESS_____
Street *City* *Province* *Postal Code*

Telephone # _____

EDUCATION PROGRAM FOR WHICH ASSISTANCE IS REQUESTED FOR

PROGRAM_____

INSTITUTION_____

Duration of Program _____ **Commencement** _____

Anticipated Completion Date _____ **Intended Career** _____

Full time Study? Yes No **Part time Study? Yes No**

Accepted into Program? Yes No

If no, when do you expect to accepted_____

FINANCIAL INFORMATION

Cost of Tuition	
Other related costs: books, travel, etc.)	
Financial Need: (dependents, etc.)	
Other Bursaries, awards received	
Bursaries previously received from Seven Oaks General Hospital (Name of bursary & year received)	

****** Proof of acceptance into program is required prior to provision of funding.**

EDUCATIONAL BACKGROUND

List names of educational institutions you have attended and your academic standing in sequence, listing most recently attended first.

Institution	Academic Standing

*****An official copy of your most recent transcript is required prior to provision of funding.**

VOLUNTEER/WORK/COMMITTEE EXPERIENCE

(where, year(s), amount of time)

REFERENCES

A minimum of <u>two</u> written letters of reference must accompany the bursary application, one of which should be from a member of the teaching staff of the educational institute the applicant attended.

Name _____ **Position** _____

Address _____
Street *City* *Province* *Postal Code*

Business Phone _____ **Home Phone** _____

Name _____ **Position** _____

Address_____
Street *City* *Province* *Postal Code*

Business Phone _____**Home Phone** _____

NOTE: All references must be received by
Friday, April 27th, 2018

DECLARATION OF APPLICANT

I hereby accept the following obligations upon acceptance of financial assistance from Seven Oaks General Hospital.

1. **Submission of proof of completion of the school year.**

2. **Return the total amount of the award immediately or as arranged by Seven Oaks General Hospital should the year not be completed.**

I hereby certify that the information is complete and true to the best of my knowledge and understand and agree to abide by the stated responsibilities upon acceptance of financial assistance.

Please review checklist to ensure a complete application.

Date _____ **Signature of Applicant** _____