SCHOLARSHIP APPLICATION

Please complete all sections below. Please download this form and print clearly. Any areas that do not apply to applicant should be marked "N/A" or non-applicable. Incomplete applications may be returned to applicant for further clarification.

GENERAL INFORMATION

NAME:

____
Last First Middle or Initial

PERMANENT MAILING ADDRESS:

____
Street City State Zip

PERMANENT HOME TELEPHONE NUMBER:

(______)__________________________ ______________________________________
E-Mail Address

****

INSTITUTIONAL INFORMATION

____
Name of School Planning to Attend

____
Street Address City State Zip

(______)________________________________
Telephone Number

Currently enrolled: ___________ Yes _________ No

Scholarships may be awarded in the following areas of study: Dentistry, Dental Assisting, Dental Hygiene, Dental Laboratory Technician.

Please complete the question below that describes your situation at the time of this application.

1. I have applied for ___________________________________ but have not yet been accepted.
(your area of study)

2. I have been accepted as a student in _________________________________ and I will begin training on ____, ______
(your area of study) (month) (year)

and graduate on (or about) ________________________________, ____________________.
(month) (year)

3. I am currently a student in ____________________________ and will graduate on (or about) _______, ______.
(your area of study) (month) (year)

4. Other (please describe):____
____
____

FINANCIAL INFORMATION

Use previous tax year's records to complete information requested below:

Assets

Cash, savings, and checking accounts	$__________________.00
Other real estate and investments value	$__________________.00
20____ total number of exemptions (Form 1040-line 6e, or 1040A-line 6e; 1040EZ filers)	$__________________.00
20____ Adjusted Gross Income (AGI-Form 1040-line 31, 1040A-line 16, or 1040EZ-line 4)	$__________________.00
20____ U.S. income tax paid (Form 1040-line 46, 1040A-line 25, or 1040EZ-line 8)	$__________________.00
20____ Income earned from work	$__________________.00
20____ Untaxed income and benefits (yearly totals only)	
Social Security Benefits	$__________________.00
Aid to Families with Dependent Children (AFDC or ADC)	$__________________.00
Child support received for all children	$__________________.00
Other untaxed income and benefits	$__________________.00

Other financial aid received: *(List source(s) and amounts)*

1.____	$__________________.00
2.____	$__________________.00
3.____	$__________________.00
4.____	$__________________.00
5.____	$__________________.00

Liabilities:
List all liabilities below including monthly payment, balance due on account (if any), and anticipated date of final payment:

MONTHLY PAYMENT	BALANCE DUE ON ACCOUNT	ANTICIPATED FINAL PAYMENT DATE
$	$	
$	$	
$	$	
$	$	
$	$	
$	$	
$	$	
$	$	
$	$	
$	$	

BIOGRAPHICAL/REFERENCE INFORMATION

Give a brief personal statement below (**Please type**). Include family experiences, community service, leadership positions, your reasons for choosing a career in the dental field, and your long-term goals. (If more space is needed, attach additional pages to application.) Attach two (2) letters of reference in support of your application. One of the references needs to be from a dentist. These letters should reference your application by name and **must be typed.** References may be contacted by the Selection Committee.

READ AND SIGN
Certification: All of the information provided by me or any other person on this form is true and complete to the best of my knowledge. If asked by an authorized official, I agree to give proof of the information that I have given on this form. I realize that if I do not give proof when asked, I may be denied aid.

____
Signature of Applicant

____
Date Completed

For Iowa Dental Foundation Use Only:

Date application received by Foundation: /__/______/______/Date application reviewed: //_____/______/

Amount of grant request: $____________________.00 Amount of grant awarded: $____________________.00

Date of grant award: /______/______/______/ Check Number: _______
____

Comments: ____
____
____
____
____
____
____
____

____ ____________________________
Iowa Dental Foundation Board of Directors President Date

Return to:
Iowa Dental Foundation
P.O. Box 31088
Johnston, IA 50131-9428

Deadline: March 31 of each year