



SCTPN | 84 /East 52nd Street | Brooklyn, NY 11203-1906
T/F: 877.812.4216 | www.sctpn.org

SCHOLARSHIP APPLICATION

Please check one:

New Applicant

Returning Applicant

APPLICANT INFORMATION	
NAME:	DATE OF BIRTH:
ADDRESS:	TELEPHONE: (H) (W)
CITY/PROVINCE: STATE: ZIP:	EMAIL:
SCHOOL INFORMATION	
NAME:	MAJOR: MINOR:
ADDRESS:	GPA:
CITY/PROVINCE: STATE: ZIP:	EXPECTED GRADUATION DATE:
Please check one:	
High School Senior <input type="checkbox"/>	College Freshman <input type="checkbox"/> Sophomore <input type="checkbox"/> Junior <input type="checkbox"/> Senior <input type="checkbox"/>

_____	_____
Academic Advisor/Dean	Signature
_____	_____
Applicant	Signature

WORK EXPERIENCE <i>(Current resume may be attached)</i>	
NAME OF EMPLOYER: DATE OF EMPLOYMENT: NAME OF SUPERVISOR:	BRIEF DESCRIPTION OF RELEVANT EXPERIENCE:
NAME OF EMPLOYER: DATE OF EMPLOYMENT: NAME OF SUPERVISOR:	BRIEF DESCRIPTION OF RELEVANT EXPERIENCE:

Name:

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List all extracurricular activities:

List future educational and career goals:

How do you plan to use the Sickle Cell/Thalassaemia Patients Network Scholarship?

By signing this application, I certify that the information provided above is truthful and accurate.

Signature

Date