
Lebanon Community Hospital Foundation John and Carol Dinges Medical Scholarship Application

Name of applicant: _____

Address: _____

Contact phone number: _____

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: _____