Dr. Marshall E. Hollis Family Health Care Scholarship Fund
APPLICATION

NAME _____ SEX_____

HOME ADDRESS _____PHONE NUMBER_____

CITY _____STATE_____ ZIP_____

HIGH SCHOOL ATTENDED _____

PARENTS' OR GUARDIANS' NAMES _____

FATHER'S OCCUPATION _____

MOTHER'S OCCUPATION _____

NUMBER OF CHILDREN LIVING AT HOME _____

NUMBER OF CHILDREN IN COLLEGE _____

IS OUTSIDE FINANCIAL ASSISTANCE NECESSARY TO BEGIN AND COMPLETE A FOUR-YEAR EDUCATION? YES ☐ NO ☐

IF YES, PLEASE EXPLAIN WHY _____

_____

_____

DO YOU PLAN TO BE A FULL-TIME STUDENT? _____PLEASE EXPLAIN YOUR FUTURE PLANS, AS THEY RELATE TO YOUR INTEREST IN A HEALTH CARE FIELD: _____

_____

_____

_____

GIVE NAMES OF COLLEGES TO WHICH YOU HAVE APPLIED _____

_____

_____

HIGH SCHOOL GRADE POINT AVERAGE _____ACT SCORE_____

CLASS RANK_____SAT SCORE*_____VERBAL_____MATH_____

*IF AVAILABLE

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LIST ALL EXTRA CURRICULAR ACTIVITIES DURING YOUR HIGH SCHOOL CAREER, BOTH IN SCHOOL AND OUTSIDE OF SCHOOL. (Attach a separate sheet if necessary)

Activity	Dates

To be eligible for the scholarship, a student must:

1. **Show an interest in a health care field**
2. **Be a graduating senior from a high school in Tippah County, Mississippi**
3. **Have a minimum GPA of 3.0.**
4. **Have a minimum ACT score of 20.**
5. **Plan to enroll in college as a full-time student.**
6. **Show examples of leadership in community or school programs.**

The winner of this scholarship will receive a one time award paid directly to a college or university.

RETURN APPLICATIONS TO YOUR HIGH SCHOOL GUIDANCE COUNSELOR BY MARCH 7, 2025.