



SCTPN | 1139 St. John's Place | Brooklyn, NY 11213  
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## SCHOLARSHIP APPLICATION

**Please check one:**

☐ **New Applicant**

☐ **Returning Applicant**

### APPLICANT INFORMATION

NAME:

DATE OF BIRTH:

ADDRESS:

TELEPHONE:

(H)

(W)

EMAIL:

CITY/PROVINCE:

STATE:

ZIP:

### SCHOOL INFORMATION

NAME:

MAJOR:

MINOR:

ADDRESS:

GPA:

CITY/PROVINCE:

STATE:

ZIP:

EXPECTED GRADUATION DATE:

**Please check one:**

High School Senior ☐

College Freshman ☐

Sophomore ☐

Junior ☐

Senior ☐

Academic Advisor/Dean

Signature

Applicant

Signature

### WORK EXPERIENCE *(Current resume may be attached)*

NAME OF EMPLOYER:

BRIEF DESCRIPTION OF RELEVANT EXPERIENCE:

DATE OF EMPLOYMENT:

NAME OF SUPERVISOR:

NAME OF EMPLOYER:

BRIEF DESCRIPTION OF RELEVANT EXPERIENCE:

DATE OF EMPLOYMENT:

NAME OF SUPERVISOR:

List all extracurricular activities:

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List future educational and career goals:

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

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

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Signature

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Date