TAFT COLLEGE FOUNDATION

TAFT COLLEGE FOUNDATION SCHOLARSHIP FOR COPE SCHOLARS

NURSING SCHOLAR _____ OR HEALTH SCHOLAR_____
***Select the program you are requesting funding for**

TAFT COLLEGE STUDENT ID # A_____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____EMAIL:_____

COLLEGE GRADE LEVEL: _____ COLLEGE GPA: _____

PROPOSED MAJOR /FIELD OF STUDY: _____

WHERE DO YOU PLAN TO TRANSFER? _____

WHEN? _____

WHAT ARE YOUR LONG-TERM EDUCATIONAL PLANS? _____

WHAT ARE YOUR CAREER PLANS? _____

WHAT ARE YOUR INTENTIONS FOR RECEIVING FUNDING INTO THE COPE SCHOLARS PROGRAM?

_____ _____
Applicant's Signature Date

****Applicants will be notified by Taft College Foundation of scholarship acceptance.*
Taft College Foundation Contact Information:
Sheri Horn-Bunk 661-763-7936 shorn-bunk@taftcollege.edu or Mahea Maui 661-763-7961 mmaui@taftcollege.edu

Tuition Assistance Application

Name (Last, First):_____ Site: Adventist Health Bakersfield

Program Start Date: Spring/Summer/Fall/Winter Program Track: 15 month 9 month 3 month

Reason for Assistance (check all that apply):

__ I am a single parent
__ Low income (family or self)
__ Medical reasons
__ Unemployment
__ Self-funding school
__ Providing financial assistance for others
__ Other (please explain): _____

Essay Prompt (500 words or more):

Please tell us how you hope to give back to people in your community by becoming a health care professional. Provide any additional information about your background that can help clarify your disadvantaged student status.

Applicant Agreement*: I understand that submitting this application does not guarantee tuition assistance. I understand that I will be notified of the application status, if accepted.*

Name:_____ Date:_____ Sign:_____

Office Use Only

Program Manager Name:_____ Date of Review:_____ Status:_____