



SCTPN | 1139 St. John's Place | Brooklyn, NY 11213
T/F: 877.812.4216 | www.sctpn.org

SCHOLARSHIP APPLICATION

Please check one:

SCTPN Scholarship

Karla Samuels Nursing Scholarship

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 College Freshman Sophomore Junior Senior

Academic Advisor/Dean

Signature

Applicant

Signature

WORK EXPERIENCE *(Current resume may be attached)*

NAME OF EMPLOYER: DATE OF EMPLOYMENT: NAME OF SUPERVISOR:	BRIEF DESCRIPTION OF RELEVANT EXPERIENCE:
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NAME OF EMPLOYER: DATE OF EMPLOYMENT: NAME OF SUPERVISOR:	BRIEF DESCRIPTION OF RELEVANT EXPERIENCE:
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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's or Karla Samuels Nursing Scholarships?

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

Signature

Date