# VERNA NYGAARD SCHOLARSHIP

Community HOSPICE FOUNDATION

◯ **New application** **Renewal for** ◯ Year 2 ◯ Year 3 ◯ Year 4

Student Name
First Name Middle Initial Last Name

Mailing Address
Street City State/Province Zip Code

Home Phone ( ) Cell Phone ( )
Area Code Area Code

Email High School Attending

Parent/Guardian

Home Address
Street City State/Province Zip Code

Name of Education Institution you will be Attending

**Type of program you will be enrolled in for the academic year**

◯ Bachelor ◯ Associate ◯ Technical/Trade ◯ Certification

School's Mailing Address for Scholarship Information

Street

City State/Province Zip/Postal Code

Name of Deceased
First Name Middle Initial Last Name

Relation to Applicant Date of Birth Date of Death

Applicant's Age at Time of Death Applicant's Date of Birth

**Parent/Guardian Signature** **Date**

I certify that all of the information contained in this application is accurate. I understand that Community Hospice Foundation will verify my information as part of my application for this scholarship.

**Applicant Signature** **Date**

By signing the above application for financial assistance you are authorizing Community Hospice Foundation to use your name and photo in print, social media and website award announcement.

**Application with required materials must be postmarked by May 1, 2020.**

Return completed application to: Verna Nygaard Scholarship Fund, Community Hospice, 4368 Spyres Way, Modesto, CA 95356.