



**APPLICATION FOR VILLAGE IMPROVEMENT ASSOCIATION OF DOYLESTOWN
WOMEN'S SCHOLARSHIP FUND**

**** All information must be completed****

PERSONAL DATA

Name _____

Address _____

Phone: Home _____ Work/Cell _____

Student ID # _____

U.S. Citizen: YES NO

Bucks County Resident YES NO

Date of Birth _____ Age _____

Marital Status: Single Married Separated Divorced Widowed

Dependents

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

EMPLOYMENT & INCOME

Employer _____

Occupation _____ Title _____

Employer Address _____

Employer Phone _____

Full Time Part Time How Long? _____

Gross Monthly Income _____

Spouse's Employer & Income _____

Occupation _____ Title _____

Employer Address _____

Employer Phone _____

Full Time Part Time How Long? _____

Gross Monthly Income _____

Assets _____ Liabilities _____

FINANCIAL DATA

Amount Requested \$ _____

How will you be using this scholarship, if you are selected?:

Source of Funds Available

Family _____ Other _____

What agencies have you contacted for help?

Agency _____ Contact _____ Phone _____

Agency _____ Contact _____ Phone _____

EDUCATION INSTITUTION

Name of Institution _____

Address _____

Contact _____ Phone _____

Course of Study _____

Returning to course/program or newly enrolled: _____

Certificate/Diploma Sought _____

Date Expected to Complete _____

Cost of Program or Class \$ _____

By what date must award be submitted to Institution? _____

Include Letter of Recommendation

Other References (not relatives)

Name _____

Address _____

Phone _____

Name _____

Address _____

Phone _____

Name _____

Address _____

Phone _____

Tell us about yourself in 250 words or less. (Please use a separate piece of paper)

Mail to: Doylestown Hospital/VIA Women's Scholarship Fund
595 West State Street, Doylestown, PA 18901

All requests and awards are kept confidential