



Kentucky Public Health Association's
Public Health Workforce Development Scholarship
Application Form

Applicant Contact Information:

Name _____
Address _____ City _____
State Kentucky Zip _____
Email _____ Phone _____

University Information:

1. Please write the name, address and phone number of the educational institution that you will be attending for the grant year.

University/College _____
Address _____
Phone: () _____ - _____ College Major _____
Cumulative College GPA _____

2. What is your current college level?
3. How many credits have you completed and are you currently taking? **Please attach copy of current school transcript.**
4. Are you a current member of KPHA?
5. Have you ever been awarded any other scholarship offered through the Kentucky Public Health Association?
 Yes
 No
6. Are you currently employed or have you ever been employed in a health department, public health organization, or health related government agency?
 Yes
 No

Employer's Name _____
Address _____ Phone () _____ - _____
Date Started _____ Date Left _____ Position _____
Full time ___ Part time ___



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7. Do you receive financial support from a parent, guardian, spouse, or any other organization?
- Yes
 No

Briefly describe any financial assistance you are receiving or will be receiving in the upcoming academic year.

8. Please supply a short summary of your future career goals.
9. Please provide a description of any public service, in which you performed. Please include year(s) and organization service was provided for.
10. Please attach 3 Letters of Support or Recommendations.

I give my permission to the Kentucky Public Health Association to obtain financial and educational information from my educational institution. I also understand that the Kentucky Public Health Association may contact any employers I have listed for verification of employment.

Student's signature _____ Date _____

NOTE: APPLICATIONS WITHOUT A TRANSCRIPT AND/OR WITH UNANSWERED QUESTIONS WILL BE INELIGIBLE.

THANK YOU FOR APPLYING!