IOWA DENTAL FOUNDATION SCHOLARSHIP APPLICATION

Please save this form on your computer and complete all sections below. Any areas that do not apply to applicant should be marked "N/A" or non-applicable. Incomplete applications may be returned to applicant for further clarification.

GENERAL INFORMATION

Name:

Last First Middle I

Permanent Mailing Address:

Street Address City State ZIP

Permanent Home Telephone Number:

( ) -

Email Address

INSTITUTIONAL INFORMATION

Name of School Planning to Attend

Street Address City State ZIP

( ) -

Telephone Number

Currently enrolled: ☐ Yes ☐ No

Scholarships may be awarded in the following areas of study: Dentistry, Dental Assisting, Dental Hygiene, Dental Laboratory Technician.

Please check and complete the statement below that describes your situation at the time of this application.

☐ I have applied for _____ but have not yet been accepted.
(your area of study)

☐ I have been accepted as a student in _____ and I will begin training on _____, _____,
(your area of study) (month) (year)

and graduate on or about _____, _____.
(month) (year)

☐ I am currently a student in _____ and will graduate on or about ____ , _____.
(your area of study) (month) (year)

☐ Other(Please describe):

FINANCIAL INFORMATION

Use previous tax year's records to complete information requested below:

Assets:

Cash, savings, and checking accounts	$	.00
Other real estate and investments value	$	.00
20 ____ Total number of exemptions (Form 1040-line 6e, or 1040A-line 6e; 1040EZ Filers)	$	.00
20 ____ Adjusted Gross Income (AGI-Form 1040-line 31, or 1040A-line 16, or 1040EZ-line 4)	$	.00
20 ____ U.S. income tax paid (Form 1040-line 46, 1040-A-line 25, or 1040EZ-line 8)	$	.00
20 ____ Income earned from work	$	.00
20 ____ Untaxed income and benefits (yearly totals only)		
Social Security Benefits	$	.00
Aid to Families with Dependent children (AFDC or ADC)	$	.00
Child support received for all children	$	.00
Other untaxed income and benefits	$	.00

Other financial aid received: (*List source(s) and amount(s)*

1. _____	$	.00
2. _____	$	.00
3. _____	$	.00
4. _____	$	.00
5. _____	$	.00

Liabilities:

List all liabilities below, including monthly payment, balance due on account (if any), and anticipated date of final payment.

Monthly Payment	Balance Due on Account	Anticipated Final Payment Date
$	$	
$	$	
$	$	
$	$	
$	$	
$	$	
$	$	
$	$	
$	$	
$	$	

BIOGRAPHICAL/REFERENCE INFORMATION

Give a brief personal statement below. Include family experiences, community service, leadership positions, your reasons for choosing a career in the dental field, and your long term goals. (If more space is needed, attach additional pages to application.) Attach two (2) letters of reference in support of your application. **One of the references needs to be from a dentist.** These letters should reference your application by name and **must be typed.** References may be contacted by the Selection Committee.

READ AND SIGN

Certification: All of the information provided by me or any other person on this form is true and complete to the best of my knowledge. If asked by an authorized official, I agree to give proof of the information that I have given on this form. I realize that if I do not give proof when asked, I may be denied aid.

Signature of Applicant Date Completed

For Iowa Dental Foundation Use Only:

Date application received by Foundation: ___/___/_____ Date application reviewed: ___/___/_____

Amount of Grant Request:	$ .00	Amount of Grant Awarded:	$ .00
Date of Grant Award:	/ /	Check Number:	
Comments:			
Iowa Dental Foundation Board of Directors President			Date

Please complete and return application to:

Email: Stacy@iowadental.org

or

Iowa Dental Foundation
8797 NW 54th Avenue, Suite 100
Johnston, IA 50131-9428

Application Deadline: March 31 of each year