****

**NOCCC Scholarship Program**

**Scholarship Application Form**

**2022-23**

**Directions:** This form should be completed by the student.

**Student’s Last Name First Name Middle Initial**

**Current Address City, State, Zip Code**

**Permanent Address (if different from above) City, State, Zip Code**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address**

\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age**  **Do You Have a Disability (Please Circle):** Yes No

**Race (Please Circle):**

African American/Black Latino/Hispanic

American Indian/Alaska Native Asian

Pacific Islander Other (Please Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you know someone (e.g., family member) who is a member of North Omaha Community**

**Care Council? (Please Circle):**

No Yes (Please Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who referred you to apply?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**High School Attended**  **City, State**

**College/University Name** **City, State**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Scholarship Amount Requested** **Student’s Major/Degree**

**TURN OVER 🡪**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expected Family Contribution (EFC) Current Year in College**

**Current Grade Point Average**

1. Do you intend to apply to a health professional school (e.g. Medical School, Physician Assistant, Nursing, Occupational Therapy, and PHYSICAL Therapy) at any time after graduation?

**Yes No**

2. Will you apply to UNMC, UNO, Creighton University, or any other Nebraska

University for admissions to any of the health professional schools they offer?

**Yes No**

3. Which health professional schools are you aware of at UNMC? (Check All That

Apply):

**\_\_Medicine**

**\_\_Nursing**

**\_\_Physician Assistant**

**\_\_Physical Therapy**

**\_\_Respiratory Therapy**

**\_\_Occupational Therapy**

**\_\_Pharmacy**

**\_\_Public Health**

**\_\_Other (Specify):\_\_\_\_\_\_\_\_\_\_\_**

Please complete this NOCCC Scholarship Application Form, provide a copy of current enrollment/registration, and return scanned copies via email or by postal mail to:

**NORTH OMAHA COMMUNITY CARE COUNCIL**

**P.O. BOX 31341, OMAHA, NE 68132**

 **EMAIL:** MAIL@NOCCC.ORG