Kentucky Board of Medical Imaging and Radiation Therapy

125 Holmes Street, Suite 320
Frankfort, KY 40601
Phone: (502)782-5687

For Office Use Only:

Scholarship Application- Verification of Student Status

Applicant Information

Applicant Full Name: _____
Last *First* *M.I.*

Social Security Number _____-_____-_____ Date of Birth: _____/_____/_____
Month *Day* *Year*

Education Information

PROGRAM ADMINISTRATOR: Please complete the portion below and return it to student.

Name of educational institution: _____

Address: _____
Street Address *City* *State* *Zip*

Type of program: _____

Beginning Date for Program:_____ Expected Date of Completion: _____

Number of Credit Hours Estimated for Completion: _____ Grade Point Average: _____
If no post-secondary GPA, use high school GPA

The student is enrolled for _____ credit hours for the: ☐ Spring 20__ ☐ Summer 20__ ☐ Fall 20__ semester.

Comments:_____
_____

Name of Administrator: _____ Title: _____

Telephone Number:_____ Email Address:_____

_____
Administrator's Signature: *Date::*

Disclaimer and Signature

APPLICANT: Sign and date the certification and authorization for release of information.

I affirm that all the information reported is complete, accurate, and true to the best of my knowledge. I understand that if I do not meet the obligation of this program, I will be required to repay the scholarship funds received plus accrued interest. I understand that I will be required to sign a promissory note and contract to receive the scholarship funds.

I authorize school/program officials to release the information requested to the Kentucky Board of Medical Imaging and Radiation Therapy for the purpose of determining eligibility for the scholarship.

Signature of Applicant: _____ Date: _____