

Grace E. and Daniel W. Patrick Scholarship Fund Application

Name: _____ DOB: _____

Phone: _____ Email: _____ SSN last 4 _____

Address: _____ City: _____ State: _____ Zip: _____

Dates you were a patient at Shriners Children's Spokane: _____

If unsure call 509-744-1225

Parent/Guardian if under 21: _____

Name: _____ Phone: _____

Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of College, technical or vocational school: _____

Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Degree or Certificate you are pursuing: _____ Length of Program: _____

Student ID# _____ Cumulative GPA if applicable: _____

What year will you be starting this year: 1st 2nd 3rd 4th

Narrative describing how Shriners Children's Spokane has affected the life of you and your family 2000 characters (including spaces) maximum

Narrative describing honors and awards you have received, community service, civic and liberty activities and your values and goals 2000 characters (including spaces) maximum

Parent Guardian Signature _____ Date _____

Applicant Signature _____ Date _____