

Dear Applicant:

Each year the Cody Medical Foundation awards \$1,000 grants to qualified students. To be eligible for these grants, the applicant or his parents must live in the West Park Hospital District. The Foundation further requires that one year of college work be completed before application is made and that a college transcript is included when submitting the scholarship form. All scholarship applications must be received at the following address before August 1<sup>st</sup>. Mail to:

CODY MEDICAL FOUNDATION  
721 Sheridan Avenue  
Cody, Wyoming 82414

1. Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

2. Permanent Mailing Address: \_\_\_\_\_  
Street/P.O. Box City State Zip Code

3. Permanent Residence & Legal Address: \_\_\_\_\_  
Street City State Zip Code

4. Parents' Name & Mailing Address: \_\_\_\_\_  
Street /P.O. Box City State Zip Code

5. Parents' Permanent Residence & Legal Address: \_\_\_\_\_  
Street City State Zip Code

6. Marital Status: \_\_\_\_\_ Children: \_\_\_\_\_

7. Applicant's Employment Experience. (List most recent first)

Employer	Type of Work	Date	Amount
_____	_____	_____	\$ _____
_____	_____	_____	_____
_____	_____	_____	_____

8. Student's Own Assets:

Nature of Assets	How Obtained	Value	Unpaid Balance
_____	_____	\$ _____	\$ _____
_____	_____	_____	_____
_____	_____	_____	_____

9. Estimate of Expenses for Year:

Fees and Tuition	\$ _____
Personal	_____
Board and Room	_____
Other	_____
Total	\$ _____

10. Funds Available for Student from:

Source	Amount
Parents	\$ _____
Student's Assets	_____
Summer Wages	_____
Grants	_____
Scholarships	_____
Educational Loans	_____
Work Study	_____
Social Security Benefits	_____
G.I. Benefits	_____
Trust Funds	_____
Any Other Sources of Income	_____
Total	\$ _____

11. Estimated amount of additional financial help needed for school year.  
(Item 7 less item 8) \$ \_\_\_\_\_

(OVER)

12. Please state why this request for funding of your education cannot be obtained from another source.

13. Prior Education Background

High School

Medical School or College

Major Course of Study

Years of Training now completed

GPA

ACT or SAT Score

14. Write a brief statement telling of your goals in the medical profession and post graduation plans.

Statement:

15. Please include three letters of reference.

I hereby certify that the above information is true to the best of my knowledge.  
It is necessary that I obtain financial assistance in order to complete my education.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Student's Signature