# McLeod

## Regional Medical Center

**(Note: Please supply envelope and stamp for reference.)**

**I,____________________________________, am applying for a health related scholarship from the McLeod Regional Medical Center Auxiliary. I hereby authorize the release of the requested information to the McLeod Volunteer Auxiliary.**

________________________________ ________________________

**Signature** **Date**

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1. **When did you first know the applicant? From ______________ To______________**
2. **What is your relationship to the applicant? (No relatives)**

   **____ Supervisor/Employer** **____ Guidance Counselor**

   **____ Teacher** **____ Coach**
3. **Please describe the applicant in terms of quality of work, dependability, cooperation, initiative, and attitude.**

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**Additional comments:**______________________________________________

____________________________________________________________

**SIGNATURE:**________________________________ **Date:**_______________

______________________ ______________________ ___________

**Street or P.O. Box** **City, Sate, Zip Code** **Phone**

**Please mail this form directly to:**
**VOLUNTEER SERVICES, SCHOLARSHIP COMMITTEE**
**McLeod Regional Medical Center**
**P.O. Box 100551, Florence, SC 29502-0551**

**<u>BY: JUNE 5TH PRIOR TO FALL TERM</u>**