DR. RON W. ZUFALL
DENTAL AND HEALTH CARE SCHOLARSHIP

SCHOLARSHIP APPLICATION COVER

NAME: _____
Last First MI

ADDRESS: _____

CITY/STATE/ZIP_____

PHONE NUMBER:_____**EMAIL:**_____

DATE/PLACE OF BIRTH: _____

COLLEGE YOU HOPE TO ATTEND: _____

Have you been accepted by this college? Yes____ No_____

If no, what are your plans? _____

SCHOOL RECORDS

4 year high school GPA_____(unweighted)_____(weighted)

S.A.T. English _____ Math _____ Reading_____ Total _____

A.C.T. _____

Scholarship winners agree to allow their name (first name only), school and likeness, to be announced at the office of Dr Zufall, on the office webpage (www.drzufall.com) or on the office facebook page (Ron W. Zufall, DDS).

_____Applicant_____date

_____Parent/Guardian_____date