APPLICATION
HEALTHCARE OCCUPATION EDUCATION ASSISTANCE
SAC-OSAGE HOSPITAL FOUNDATION

PO BOX 451
OSCEOLA, MO 64776

NAME: ______________________________

RESIDENCY ADDRESS: ______________________________

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PHONE: ______________ EMAIL ______________

AGE: ________

CURRENT OCCUPATION: ______________________________

MARRIED? ______________

CHILDREN AT HOME ______________

EDUCATIONAL GOAL: ______________________________

____

____

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LENGTH OF STUDY (Semesters, Months, Hours as appropriate) ______________

ARE YOU ALREADY ENROLLED? IF SO, HOW LONG DO YOU HAVE LEFT?

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In pursuit of my Educational Goal, I have been accepted into the following program:

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______________________________ Rev Jun 21

ATTACHMENTS:

Proof of Sac-Osage Hospital District Residency: Attach copy at least one of the following:

Page 1 of Form 1040 tax return;
Real Estate tax receipt; Personal Property tax receipt;
Voter registration;
School Record;
Social Services Letter
Utility bill
Driver Licence

Evidence of having been accepted into the desired course of study.

SIGNATURE:

I above information and attachments are true and accurate:

____________________________ ____________________________

Printed Name: First Last

____________________________ ____________________________

SIGNATURE DATE

(Return completed application and attachments to the above address)