Cleveland Clinic
Education Institute

Application for the Robert D. Kruse Memorial Scholarship

Name: _____
(First) (Middle) (Last) (Maiden)

Present Address: _____
(Street) (City) (State) (Zip)

Permanent Address: _____
(if different) (Street) (City) (State) (Zip)

Contact Information: _____
(Email Address) (Cell Phone Number)

School Information: _____
(Name of Program Currently Enrolled) (Expected Graduation Date)

Foreign Applicants: _____
(Designated Immigration Status) (Expiration Date)

Grade Point Averages: _____
(Cumulative Undergraduate GPA) (Cumulative Graduate GPA, if applicable)

Education: List all colleges and universities attended; with the most recent (current) listed first.

College/University Name	City / State	Start & End Dates (Month/Year)	Degree
	/	/ & /	
	/	/ & /	
	/	/ & /	
	/	/ & /	

Recommendations: List the contact information for <u>two</u> individuals who will complete your recommendation forms. (NOTE: One recommendation <u>must</u> come from a faculty member of your health science program.)

Name / Title	Affiliation	Address	Contact Information
/			Email: Phone:
/			Email: Phone:

Describe any volunteer, mentoring, or service learning experiences you have had since enrolling in college. (NOTE: Please EXCLUDE shadowing experiences or those service learning experiences that are requirement for your program.)

If you had or will have clinical rotation/s at a Cleveland Clinic facility, please indicate the facility, CCF discipline representative, the date or pending dates of the rotation, and type of clinical rotation.

Have you ever been convicted of a felony? ☐ Yes ☐ No
If Yes, please explain: _____

Have you ever been debarred from participating in Federal Health Care Programs? ☐ Yes ☐ No
If Yes, please explain: _____

Do you have student loans? ☐ Yes ☐ No
If Yes, please explain: _____

Have you received other scholarships while attending college? ☐ Yes ☐ No
If Yes, please explain: _____

Will you receive any other financial assistance this academic period? ☐ Yes ☐ No
If Yes, please explain: _____

Do you consider yourself a traditional or non-traditional student? ☐ Traditional ☐ Non-Traditional
Please explain: _____

Examples of a non-traditional student may include someone who:
Delayed enrollment, works full-time (35 hours or more per week) while enrolled, has dependents other than a spouse (usually children, but sometimes others) or is a single parent.

Please print, then sign and date.

_____
(Signature) (Date)

See Mailing Instructions below!

Mail all application documents together in <u>one</u> envelope to the address noted below.

Documents include:

- **Application**
- **FAFSA Student Aid Report (SAR)**
- **Typewritten Statement**

Faculty Recommendation and Waiver Forms should be returned directly by the instructor to the address below. Two recommendation forms are required, letters may also be sent in addition to the required form. One recommendation must come from a faculty member of your health science program.

Official Transcripts are to be sent directly by the school – no exceptions!

Faculty Recommendations and Transcripts received with the Application will <u>not</u> be considered.

Please do <u>NOT</u> staple any documents.
Please do <u>NOT</u> print any documents double-sided.

Cleveland Clinic
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Health Professions' Education Council
9500 Euclid Avenue / NA22
Cleveland, OH 44195