

FLORIDA DENTAL HEALTH FOUNDATION
DENTAL ASSISTING SCHOLARSHIP
REVIEW REQUIREMENTS

1. Applicant must have lived in Florida for at least two years.
2. Applicant must have completed 12 credit hours or 300 clock hours in a dental assisting program approved by Florida Board of Dentistry.
3. Submit completed and signed application form.
4. Include an **official sealed grade transcript** reflecting at least a 2.5 cumulative GPA from the dental assisting program.
5. Include a letter of reference from the dental assisting program director validating your financial need. Letter must be on school letterhead with an original signature.
6. Please attach a separate sheet on why are you interested in becoming a Dental Assistant.

Do not include this page with your submission

Incomplete applications will not be considered or acknowledged.

**FLORIDA DENTAL HEALTH FOUNDATION
DENTAL ASSISTING SCHOLARSHIP
APPLICATION FORM**

Name _____ email: _____

Address _____
(Please provide previous addresses if less than 2 years at this address.) City State Zip

Home Phone _____ (area code) Work Phone _____ (area code)

Are you currently employed? _____ If yes, occupation: _____

Name of Employer: _____ Salary \$ _____ / year

Education

Expected graduation date from Dental Assisting program: _____

College/Community College _____ GPA _____

High School _____ Year Graduated _____

Technical School _____ Year Graduated _____

Are you listed as a dependent on parent's tax returns? Yes _____ No _____

Please provide parent information **only** if you are listed as a dependent:

Father's name _____

Address _____
City State Zip

Occupation _____ Salary \$ _____ /yr

Mother's Name _____

Address _____
City State Zip

Occupation _____ Salary \$ _____ /yr

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Are you currently: _____ Single _____ Married _____ Divorced _____ Widowed

Do you have any children?: ____ Yes ____ No If Yes, how many are your dependents? _____

Ages of Dependents: _____

If married, Spouse's occupation: _____ Current salary \$ _____ /yr

Where do you plan to work after completing the assisting program? _____
city or county

Do you plan to work in general dentistry _____ or specialty (if yes, please specify) _____

Do you plan to continue your education in dentistry (hygiene or dentist)? _____

List financial assistance from other sources: (specify type and amount, including room and board, scholarships, student loans, child support, etc.)

I attest that to the best of my knowledge all the above information is correct.

Signature

Date

Return completed application and support documents to:

Florida Dental Health Foundation
Attn: Cheri Sutherland
1111 E. Tennessee St.
Tallahassee, FL 32308-6914