

FLORIDA DENTAL HEALTH FOUNDATION
DENTAL ASSISTING SCHOLARSHIP
REVIEW REQUIREMENTS

1. Applicants must have lived in Florida for at least two years
2. Applicant must have already completed 12 credit hours or 300 clock hours in an dental assisting program approved by Florida Board of Dentistry
3. Submit a thoroughly completed and signed application
4. Submit an official sealed grade transcript reflecting at least a *2.5 cumulative* GPA
5. Submit a letter of reference from the dental assisting program director validating your financial need

NOTE: Incomplete applications will not be considered by the review committee.

FLORIDA DENTAL HEALTH FOUNDATION
DENTAL ASSISTING SCHOLARSHIP
APPLICATION FORM

Name _____ email: _____

Address _____
City State Zip

Home Phone _____ Work Phone _____

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

Name Of Employer: _____ Salary \$ _____

Education:

College/Community College _____

Year (1st, 2nd, Freshman, Sophomore, etc.) _____ Degree Sought _____ GPA _____

High School _____ Year Graduated _____

Technical School _____ Year Graduated _____

Note: Official grade transcript of highest level of education achieved must be attached to application.

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 _____ Yearly Salary _____

Mother's Name _____

Address _____

City State Zip

Occupation _____ Yearly Salary _____

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 yearly salary? _____

Why are you interested in becoming a Dental Assistant? (attach additional sheets if necessary)

Which accredited Florida Dental Assisting School(s) has accepted you?

School: _____ Program Director _____

School: _____ Program Director _____

In what Florida County and/or City do you plan to work after receiving your degree? _____

Have you ever received a FDHF Scholarship before? No _____ Yes, Date _____

Do you received financial assistance from other sources? __No __ Yes (please specify below)

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

Signature

Date

Return this completed application and support documents to:

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

Attach support documents:
Official Grade Transcript
Letter of Need From Program Director