



# Massachusetts Hispanic Dental Association

## Official Scholarship Application

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_

Complete Mailing Address:

\_\_\_\_\_

Email Address (If any):

\_\_\_\_\_

Home Phone: \_\_\_\_\_ School Grade Average \_\_\_\_\_

Volunteer Work:

\_\_\_\_\_

\_\_\_\_\_

Awards/Honors Received: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Memberships in Clubs /Offices held:

\_\_\_\_\_

\_\_\_\_\_

College attending:

\_\_\_\_\_

Ambition for Future:

\_\_\_\_\_

Explain why you feel YOU are the best candidate to receive this Scholarship  
(In APPROX 100 words)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In order to be considered

This application MUST receive by MHDA with a copy of grades verification  
(REPORT CARD) and copies of supporting documentation of awards /  
Certificates, volunteer work, etc.,.

SIGNED:

DATE

Legal Guardian must also sign if Applicant is under 18 years old \_\_\_\_\_

MHDA a non-profit organization.