

## SCHOLARSHIP FOR STUDENT DENTAL HYGIENE AWARD

### CDHS SCHOLARSHIP GUIDELINES

The scholarship applicant must:

Be a resident of Georgia

Be attending an accredited Dental Hygiene School in Georgia

Have completed at least one quarter or semester of study in the dental hygiene curriculum

Have and maintain a 3.0 (B) average

Intend to practice in Georgia for two years following graduation

Truly be in financial need

BE A MEMBER OF SADHA

The scholarship applicant must supply:

Three written character references no more than 50 words, (one to include Dental Hygiene Director or Clinical Supervisor)

Transcripts from high school and/or all institutions attended since, including dental hygiene school

Applications must be received before MARCH 3, 2011.

Applicants will be judged on academic achievement, basic need and personal character.

The Scholarship Committee shall review the applications and make recommendations to

the Board of Trustees, who will make the final decision. Incomplete or late applications will not be considered.

In the event the scholarship recipient does not complete the dental hygiene course, any funds awarded under the scholarship shall be regarded as a non-interest bearing loan to be repaid. The student will be required to sign an agreement to this effect.

The scholarship(s) will be awarded at graduation ceremony , May -2011..

Scholarship Application

CHEROKEE DENTAL HYGIENISTS' SOCIETY

APPLICATION FOR SCHOLARSHIP

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Dental Hygiene School: \_\_\_\_\_ City: \_\_\_\_\_

Source and amount of funds available:

Your income: \_\_\_\_\_ Aid from parents: \_\_\_\_\_

Scholarships: \_\_\_\_\_ Loans: \_\_\_\_\_

Name of parent, guardian or spouse: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Company, Position held: \_\_\_\_\_

Three written character references on separate cover (one to include Dental Hygiene Director or Clinical Supervisor). A separate recommendation form must be used for each reference.

1.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

2.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

3.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Application deadline MARCH 3, 2011. Only completed applications will be considered.  
Completed

application should be sent to:

Debbie Wheeling, RDH

1565 Green Dr. Canton, Ga. 30114

Questions? E-mail Debbie Wheeling- : [ddwheeling1@alltel.net](mailto:ddwheeling1@alltel.net)

SCHOLARSHIP APPLICANT RECOMMENDATION FORM

CHARACTER REFERENCE FOR CDHS SCHOLARSHIP APPLICANT

NAME OF APPLICANT: \_\_\_\_\_

The above applicant has applied for a scholarship given by the Cherokee Dental Hygienists' Society and has given you as a reference. Please appraise the applicant in respect to those qualities which you have been in a position to evaluate. Your report will be held in strict confidence.

REFERENCE NAME: \_\_\_\_\_

Position or business: \_\_\_\_\_

In what capacity and for how long have you known the applicant?

Please rate the applicant in the following areas:

Area: Excellent Average Poor Don't know

Scholarship

Initiative

Dependability

Responsibility

Compatibility

Emotional Stability

Cooperation

Appearance

ADDITIONAL COMMENTS (Additional information and/or comments that will be helpful in evaluating the applicant):

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

