



2019 ROGER W. COOPER SCHOLARSHIP APPLICATION  
Augusta Health  
P.O. Box 1000  
Fishersville, VA 22939  
(540) 932-4190 – Community Outreach Department

Please complete all sections of the application and email it to the Community Outreach Office at [ecampbell3@augustahealth.com](mailto:ecampbell3@augustahealth.com) by April 1, 2019.

**I. General Information:**

1. Name \_\_\_\_\_ Birth Date \_\_\_\_\_

2. Contact Information

\_\_\_\_\_  
(Street Address or RFD)

\_\_\_\_\_  
(City)

\_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

\_\_\_\_\_ (Home Phone) \_\_\_\_\_ (Day Phone)

\_\_\_\_\_  
(E-Mail)

3. If you do not currently reside in the Greater Augusta County region, are you a native of the region?

\_\_\_ No \_\_\_ Yes If yes, where? \_\_\_\_\_

4. Name of college or university you attend

\_\_\_\_\_

5. Date of school term in which you plan to enroll \_\_\_\_\_

6. Intended college major \_\_\_\_\_

7. Intended occupation after graduation \_\_\_\_\_

8. Are you a veteran or an active member of the military? \_\_\_ No \_\_\_ Yes

9. Is one or both of your parents a veteran or an active member of the military? \_\_\_ No \_\_\_ Yes

10. Father's occupation (if applicable) \_\_\_\_\_ Employer \_\_\_\_\_

Mother's occupation (if applicable) \_\_\_\_\_ Employer \_\_\_\_\_

11. Number of children in family (if applicable) \_\_\_\_\_ Ages \_\_\_\_\_

12. Applicant's school history (High School & Above)	Dates Attended	Date of Graduation (or expected date)
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_____	From _____ to _____	_____
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_____	From _____ to _____	_____
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_____	From _____ to _____	_____
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13. An official transcript is required. Please have your high school send the transcript to:  
Augusta Health Scholarship Subcommittee, Augusta Health Community  
Outreach Department, P. O. Box 1000, Fishersville, VA 22939.

**II. Individual Accomplishments:** (If more space is needed for any of these items, attach additional page).

1. Community and work, school activities

Organizations:	Dates:	Leadership Positions Held/Hourly Wage for Employment
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