Labouré
COLLEGE OF HEALTHCARE

Retention Scholarship Application

Date: _____

Name: _____ Student ID#: _____
First M.I. Last

Telephone: (____)-____-____ Email: _____

Statement of Need

(Briefly state why you need financial assistance – attach additional pages if needed)

Statement of Understanding

In order for Labouré College of Healthcare to award a Retention Scholarship, certain eligibility requirements and responsibilities must be clearly understood by the student. I certify, by signing below, that I have read this form in its entirety, and I agree to the following terms:

1) I understand that I need to make satisfactory academic progress as defined by the College during any semester of my enrollment.
2) I understand that if I withdraw from any class or stop attending classes prior to the end of the semester, I may become ineligible for a portion or all of the scholarship received through the Retention Scholarship resulting in a balance owed to Labouré.
3) I understand that I may not be able to register for classes or receive official documents until I pay any debt created as a result of my withdrawal from school.

Student Signature: _____ Date: _____

****Please Note: The College will notify you via your student email address of the scholarship decision.**

Office Use Only

☐ Earned Credits*:_____ *Must have completed at least 24 credits in current program

☐ Anticipated Graduation Term: _____

☐ Meeting SAP/Good Academic Standing - criteria 2.5

Staff Signature:_____ Date_____ Approved: Yes No