Connecticut State Dental Foundation
Dr. Charles A. Vernale Scholarship Application

835 West Queen Street
Southington, CT 06489

860.378.1800

The completed application should be received no later than August 31st for enrollment in the fall semester of that calendar year. Please type or print clearly in ink.

The following must be submitted before the application can be reviewed: a) A certified transcript reflecting the most recent academic year if you are already enrolled; b) a letter of good standing (or admission if you are not already enrolled) from a dean at your school; c) a copy of your most recently filed federal tax return; d) a complete list of assets and e) a completed and signed copy of this application.

You may attach another page with additional details you think might assist the Committee in reviewing your application. The scholarship is paid directly to your school and must be applied against tuition.

Mail this completed application, with all attachments to:
Connecticut State Dental Foundation
Dr. Charles A. Vernale Scholarship Application
835 West Queen Street
Southington, CT 06489

1.
Name:_____
Last First Middle

2. Date of Birth:_____ Social Security Number:_____-_____-_____ *

3. Present Mailing Address:

_____

_____ Date Good Until:_____

Email Address:_____ Telephone #:_____

4. Permanent Address, if different from present mailing address:

_____

_____

Email Address:_____ Telephone #:_____

5. Undergraduate degree-granting school, if applicable:

_____

6. Dental/hygiene/assisting school:_____

Anticipated graduation date:_____

7. State of residency for tuition purposes, if applicable:
_____

8. Did or will someone claim you as an income tax exemption in the most recent tax

year? ____ yes _____no In which state(s) do they live?_____

9. Did parent(s), guardian(s) or spouse contribute to your support and/or education

expenses in the last twelve months? _____yes _____no If yes, how much?

$_____

Do you or your parents contribute to the support of other dependants?____yes___no___

Spouse's occupation and employer, if applicable:_____

Spouse's total annual gross income:$_____

10. Do you work or propose to work during the year?____yes____no

If yes, your monthly income, if known:$_____

Where do/will you work?_____ # of hours per
week_____

11. Are you eligible for tuition remission or waiver of tuition because of employment, veteran status or for any other reason? _____ yes _____no. If yes, please describe the type and amount:

_____

12. Please describe your interest in the dental field: _____

I certify that the above information is correct and accurate to the best of my knowledge.

_____ _____

Signature Date

* For identification purposes only