North Carolina Physicians Health Program
Family Scholarship Application

Please fill in the following information and submit to NCPHP via contacting Kim Lamando at kim@ncphp.org or by faxing it to NCPHP at 919-870-4484.

Note: You must fill in all the required information or the application will not be submitted or may be returned to you.

Name: ______________________________

Email: ________________________ Phone: __________________

Current gross (monthly) household income: __________

Savings: __________

Monthly Expenses:

Mortgage/Rent Debt: __________

Car Loans: __________

Business Loans: __________

Credit Cards: ___________

All Other Debt: __________

Number of Members in Household: __________

Are you or spouse working? __________

Description of Financial Circumstances (please be as informative as possible):

Purpose for funds: (please be as informative as possible; NCPHP will need verification of expenses incurred or anticipated or receipts or other documentation prior to providing monies).

Amount Requested: _____________

___I declare, to the best of my knowledge and belief, that the above information is true, correct and complete.

Signature: ______________________________

Check to be mailed to:

Name: _____________________________

Address: ____________________________

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NCPHP Use Only:

Approved: ____ yes ____ no (specify reason) ___________________