



ORTHODONTIC SCHOLARSHIP APPLICATION

Applicant name: _____

Number of times applicant has submitted an application for this scholarship: _____

Applicant Age: _____ Applicant Gender: _____ Applicant Grade Level: _____

Applicant Accomplishments (School, church, community): _____

Does the applicant qualify for Medicaid? Y N Is the applicant covered by dental insurance? Y N

If Yes, please specify company and policy number: _____

Parents' / Guardian Name: _____

Address: _____

Parents' / Guardian / Applicant E-mail address: _____

Responsible party phone numbers: Home: _____ Cell: _____

Parent / Guardian's Employer: _____ Household Income (annual): _____

Submitted by (circle one): Self Parent School Counselor Dentist Other _____

Contact info of person that submitted application: Phone: _____ E-mail: _____

Reference letter #1 Name: _____ Phone: _____ E-mail: _____

Reference letter #2 Name: _____ Phone: _____ E-mail: _____

Requirements:

- Applicant must be a resident of Spartanburg or Cherokee Counties in SC to be eligible.
- You must submit a 5x7 **head-shot** photo of the applicant with **full smile and teeth showing**.
- You must have two letters of reference (typed and limit each to one page).
- You must provide verification of family income, which can be last year's tax return, W-2, or a copy of the most recent pay stub.
- Answer the essay on the following page in the space provided. This is where reasons should be given as to WHY the applicant should receive orthodontic care through the Nease & Higginbotham Orthodontic Scholarship Program. Please be specific in your response.

Please mail the completed application with reference letters and picture to:

Nease & Higginbotham Orthodontic Scholarship Program
2455 East Main St.
Spartanburg, SC 29307

For questions, please contact 864.579.7700 or
info@drnease.com

