Anthony Rodriguez's Legacy of Love
SCHOLARSHIP AWARD APPLICATION

APPLICANT INFORMATION

Student's Name :_____ Major:_____

Address: _____

Email: _____

Telephone#: _____ Age: _____

Current High School (if applicable): _____

Year in College as of Fall 2024 (sophomore, etc.): _____

SCHOLARSHIP (check all that apply)

[ ] **Autoimmune Warrior**

[ ] **Medical**

[ ] **Outstanding Community**

[ ] **Speech Pathology**

EMERGENCY

Emergency Contact Name: _____ Tel#: _____

Relationship:_____

COLLEGE INFORMATION

University Name: _____ Tel#: _____

Bursar's address where check will be mailed: _____

_____

College ID: _____

VOLUNTEER INFORMATION (required for Outstanding Community Scholarship)

Organization Name: _____

Leader's Name: _____

Telephone#: _____ Email address: _____

Volunteer Dates: _____

Responsibilities **(Attach separate sheet if needed)**: _____

By signing this application, you certify that the information you have provided is accurate and you authorize the ***Anthony Rodriguez Scholarship Committee*** to verify the information.

FOR OFFICE USE ONLY	
□ APPROVED □ DENIED	REASON FOR DENIAL:

Please email this information to: **Scholarships@arlegacy.org**

The subject line should state: **AR Scholarship Request**