Broad Top Area Medical Center, Inc.

4133 Medical Center Drive P.O. Box 127
Broad Top, Pennsylvania 16621
Telephone: (814)635-2916
Fax: (814) 635-2918

Trough Creek Family Medical Center
478 Seminary Road
Cassville, PA 16623
Telephone: (814) 448-9226
Fax: (814) 448-2068

Huntingdon Family Care Center
835 Washington Street
Huntingdon, PA 16652
Telephone: (814) 506-8114
Fax: (814) 506-8553

Primary Care Center
790 Bryan Street
Huntingdon, PA 16652
Telephone: (814) 643-8300
Fax: (814) 643-8299

Pediatric Care Center
1225 Warm Springs Avenue
Huntingdon, PA 16652
Telephone: (814) 643-8574
Fax: (814) 643-8659

Woman's Care Center
1225 Warm Springs Avenue
Huntingdon, PA 16652
Telephone: (814) 643-8866
Fax: (814) 643-8867

BROAD TOP AREA MEDICAL CENTER, INC
MEDICAL SCHOLARSHIP AWARD
2017-2018

We are proud to announce our Annual Medical Scholarship Award in the amount Of $500. This award is presented annually to one graduating senior who has been accepted and enrolled in a course of study related to the health care field.

(Examples would be pre-med for medical or dental school, nursing school, or training for a career in radiology, laboratory ect.)

The Broad Top Area Medical Center, Inc Award of $500 will be sent to the college of the recipient.

Qualifications:

1. Accumulative GPA of 90% or higher for four years.
2. Enrollment in medical field of study.
3. Community and school activity involvement.
4. Two letters of recommendation from non-family members.
5. Official high school transcript.
6. Provide proof of admittance to a school of higher education.
7. Completed application signed with all attachments.

DEADLINE: April 28, 2017

CONTACT PERSON: Terry Heath

Broad Top Area Medical Center, Inc
Executive Administrative Assistant
4133 Medical Center Drive
P.O. Box 127
Broad Top, PA 16621
Telephone: 814-635-7351 EXT: 1405
Email: theath@broadtopmedical.com

BROAD TOP AREA MEDICAL CENTER, INC SCHOLARSHIP

2017-2018

APPLICANT'S NAME: _____

MAILING ADDRESS: _____

TOWN/STATE/ZIP: _____

APPLICANT'S PHONE #: _____

GPA AVERAGE: _____

MEDICAL FIELD OF STUDY: _____

SCHOOL SPONSORED CLUB/EXTRACURRICULARACTIVITES:

_____

_____

_____

LIST AWARDS FOR WHICH YOU HAVE APPLIED: _____

_____

NAME OF HIGHER EDUCATION FACILITY: _____

MAILING ADDRESS: _____

CITY/STATE/ZIP:

_____

COMMUNITY/ACTIVITY VOLUNTEER INVOLVEMENT:

_____

_____

_____

SIGNATURE OF APPLICANT: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE OF APPLICATION: _____

Please return all required information by APRIL 28, 2017 to Mrs. Gates in the Guidance Office.