HEMOPHILIA ASSOCIATION OF NEW JERSEY
SCHOLARSHIP APPLICATION FORM
UNDERGRADUATE SCHOLARSHIP APPLICATION

APPLICANT'S NAME:_____

WHICH SCHOLARSHIP(S) BELOW ARE YOU APPLYING FOR? (CHECK ALL THAT APPLY)

HANJ ____ **FRENKEL** ____ **KELLY**_____ **VELEZ** _____

HAVE YOU EVER RECEIVED AN HANJ SCHOLARSHIP GRANT? YES_____ NO_____
IF YES, DATE(S) AND AMOUNT(S): _____

BLEEDING DISORDER: HEMOPHILIA A (FACTOR VIII) ____ VON WILLEBRAND ____
HEMOPHILIA B (FACTOR IX) ____ OTHER _____

DOB: _____ TELEPHONE: _____ E-MAIL ADDRESS_____

ARE YOU PRESENTLY ATTENDING HIGH SCHOOL: YES _____ NO _____

ARE YOU PRESENTLY ENROLLED IN A COLLEGE PROGRAM: YES _____ NO _____
IF YES, SCHOOL: _____ TUITION & FEES: _____
CURRICULUM: _____NUMBER OF CREDITS EARNED TO DATE: ____
DO YOU PLAN TO CONTINUE AT THE SAME SCHOOL NEXT YEAR: YES ____ NO ____
DO YOU PLAN TO ATTEND FULL-TIME? YES____ NO ____
WHAT GRADE WILL YOU BE IN NEXT SCHOOL YEAR? _____
WHAT SCHOOLS HAVE YOU APPLIED TO FOR NEXT YEAR:
SCHOOL:_____ TUITION & FEES: _____
_____ TUITION & FEES: _____
_____ TUITION & FEES: _____

HOW DO YOU INTEND TO PAY FOR COLLEGE COSTS (E. G., LOANS, GRANTS, PARENTS):
_____
_____

IF YOU WILL BE RECEIVING FINANCIAL AID FROM SOURCES SUCH AS PARENTS, A SPOUSE OR OTHER RELATIVES, PLEASE PROVIDE THE FOLLOWING:

SOURCE: _____ SOURCE: _____
ADDRESS: _____ ADDRESS: _____
PHONE: _____ PHONE: _____

Mail this form, together with your (1) Financial statement, (2) Transcript, (3) Personal Statement, (4) school or professional photo with signed Photo Release Form, and (5) a letter from your treating physician/HTC to verify your diagnosis by **APRIL 30th** to:

HEMOPHILIA ASSOCIATION OF NEW JERSEY
ATTENTION: SCHOLARSHIP COMMITTEE
197 ROUTE 18 SOUTH, SUITE 206 NORTH
EAST BRUNSWICK, NEW JERSEY 08816