

DISABLED WORKERS' SCHOLARSHIP COMMITTEE  
c/o SUISMAN SHAPIRO, 2 UNION PLAZA, SUITE 200  
NEW LONDON, CONNECTICUT 06320

SCHOLARSHIP APPLICATION

PLEASE TYPE OR PRINT:

NAME IN FULL \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

EMAIL \_\_\_\_\_

PHONE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

**\*\* FAMILY INFORMATION \*\***

NAME OF FATHER OR GUARDIAN \_\_\_\_\_

ADDRESS IF DIFFERENT FROM OWN \_\_\_\_\_

FATHER'S PLACE OF EMPLOYMENT \_\_\_\_\_

FATHER'S OCCUPATION \_\_\_\_\_

NAME OF MOTHER OR GUARDIAN \_\_\_\_\_

ADDRESS IF DIFFERENT FROM OWN \_\_\_\_\_

MOTHER'S PLACE OF EMPLOYMENT \_\_\_\_\_

MOTHER'S OCCUPATION \_\_\_\_\_

OTHER DEPENDENTS IN THE FAMILY:

NAME	SCHOOL	AGE	GRADE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**DISABILITY INFORMATION**

In the space below, explain any unusual financial conditions carried by your family which indicates a need for financial assistance.

\*NAME OF PERMANENT AND TOTAL DISABLED PARENT \_\_\_\_\_

\*NATURE, EXTENT AND CAUSE OF DISABILITY, AND HOW WAS INJURY CAUSED BY WORK? (THE INJURY MUST HAVE ARISEN OUT OF THE WORKPLACE)

NAME AND ADDRESS OF TREATING DOCTOR \_\_\_\_\_

**ENCLOSE A DOCTOR'S REPORT AS TO THE NATURE AND EXTENT OF DISABILITY**

**\*ENCLOSE A COPY OF THE WORKERS COMPENSATION AWARD, SOCIAL SECURITY AWARD OR OTHER OFFICIAL STATEMENT CERTIFYING A PERMANENT AND TOTAL DISABILITY AND RELATION TO WORK**

## HIGHER INSTITUTION INFORMATION

What institution do you expect to attend \_\_\_\_\_

Have you been accepted at this institution \_\_\_\_\_

If you have not yet been accepted at the school of your choice, where else might you attend in the fall \_\_\_\_\_

Expected major field of study \_\_\_\_\_

What is your career goal \_\_\_\_\_

Have you filed a Financial Aid Form (FAF) with the College Scholarship Service:  
If "Yes", date filed \_\_\_\_\_

If "No", reason not filed \_\_\_\_\_

## INSTITUTION FINANCIAL INFORMATION

	YEARLY ANTICIPATED EXPENSES	YEARLY ESTIMATED INCOME	
Tuition	\$ _____	Financial Aid from Institution	\$ _____
Room & Board	\$ _____	Other Scholarships	\$ _____
Travel	\$ _____	Student Loans	\$ _____
		Parent's Contribution (Include Summer 20__ est.)	\$ _____
Other Please list:			
_____	\$ _____		
_____	\$ _____		
<b>TOTAL</b>	<b>\$ _____</b>	<b>TOTAL</b>	<b>\$ _____</b>

FINANCIAL NEED \$ \_\_\_\_\_

Subtract Total of Estimated Payments from Total of Anticipated Expenses

If there is a reason why any questions on this page cannot be answered by the applicant, please explain.

**PERSONAL FINANCIAL INFORMATION**

Amount you earned last summer \_\_\_\_\_

Place of Employment last summer \_\_\_\_\_

Hours/Week worked last summer \_\_\_\_\_

Amount you earned last School Year \_\_\_\_\_

Place of employment last School Year \_\_\_\_\_

Hours/Week worked last School Year \_\_\_\_\_

**SCHOOL AND COMMUNITY ACTIVITIES**

- 1. Academic Achievement
  - Class Standing
  - **Attach copy of Transcript of Grades to date**
  - **Provide CAPT and SAT scores**

- 2. School activities. Start with Senior year and work back to Freshman; be as specific as possible:

- 3. Community activities. Start with Senior year and work back to Freshman.

Use back if necessary

## STUDENT CERTIFICATION AND CONSENT FORM

I certify that this Application represents, to the best of my ability, the facts as I know them. I give my permission to my School to include a copy of my transcript with this Application to be reviewed by the Disabled Workers' Scholarship Committee.

Student signature \_\_\_\_\_

Date \_\_\_\_\_

## PARENT/GUARDIAN CERTIFICATION AND CONSENT FORM

I certify that this Application represents, to the best of my ability, the facts as I know them, and approve the review of my child's Application by the Disabled Workers' Scholarship Committee.

Parent/Guardian signature \_\_\_\_\_

Date \_\_\_\_\_

DISABLED WORKERS' SCHOLARSHIP COMMITTEE  
c/o 2 UNION PLAZA; SUITE 200  
NEW LONDON, CONNECTICUT 06320

REFERENCE FORM

To Whom It May Concern:

The Disabled Workers' Scholarship Screening Committee suggests that applicants submit a reference appraising the student's merit as a candidate for assistance for higher education. In the space provided below, please evaluate this student as to academic achievement, class participation, school/community involvement, or other particular information which might help the committee to make its decision.

This form should be returned to the Disabled Workers' Scholarship Screening Committee BEFORE April 1, 2015 and will be attached to the student's application. All information will be considered confidential and viewed only by members of the committee. If the form does not provide enough space for your comments, please attach a separate piece of paper.

Your assistance is greatly appreciated.

NAME OF STUDENT \_\_\_\_\_

HOW LONG HAVE YOU KNOWN STUDENT \_\_\_\_\_

IN WHAT CAPACITY HAVE YOU KNOWN THE STUDENT \_\_\_\_\_

YOUR NAME, TITLE \_\_\_\_\_

COMMENTS:

NOTE: This may be filed separately from the Application

**FAMILY FINANCIAL AFFIDAVIT**

Other Dependants: \_\_\_\_\_  
\_\_\_\_\_

Name of Applicant \_\_\_\_\_

**INCOME - YEARLY**

**EXPENSES - YEARLY**

Earned Income        \$ \_\_\_\_\_

Rent                        \$ \_\_\_\_\_

Investment Income    \$ \_\_\_\_\_

Mortgage                \$ \_\_\_\_\_

Pension                 \$ \_\_\_\_\_

Food                        \$ \_\_\_\_\_

**Disability Income**

Transportation        \$ \_\_\_\_\_

Social Security        \$ \_\_\_\_\_

Insurance                \$ \_\_\_\_\_

Workers Compensation \$ \_\_\_\_\_

Clothing                 \$ \_\_\_\_\_

Insurance                \$ \_\_\_\_\_

Medical Care         \$ \_\_\_\_\_  
(not covered by Insurance)

TOTAL                    \$ \_\_\_\_\_

Utilities                 \$ \_\_\_\_\_

Other (specify)        \$ \_\_\_\_\_

TOTAL                    \$ \_\_\_\_\_

**ASSETS**

**LIABILITIES**

Real Estate             \$ \_\_\_\_\_

Mortgage                \$ \_\_\_\_\_

Stocks & Bonds        \$ \_\_\_\_\_

Auto Loans              \$ \_\_\_\_\_

Savings                 \$ \_\_\_\_\_

Credit Cards            \$ \_\_\_\_\_

C.D.'s                    \$ \_\_\_\_\_

Other (specify)        \$ \_\_\_\_\_

Automobiles            \$ \_\_\_\_\_

TOTAL                    \$ \_\_\_\_\_

Other (specify)        \$ \_\_\_\_\_

TOTAL                    \$ \_\_\_\_\_

DATE \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent

## CHECKLIST

- \_\_\_\_\_ 1. Doctor's report as to the nature and extent of disability;
- \_\_\_\_\_ 2. Copy of PERMANENT, TOTAL DISABILITY arising out of the workplace as defined by an award from either, Connecticut Workers' Compensation, A Federal Workers' Compensation Program or Social Security Disability Award;
- \_\_\_\_\_ 3. Transcript of Grades to-date and **CAPT and SAT scores**;
- \_\_\_\_\_ 4. Essay;
- \_\_\_\_\_ 5. References;
- \_\_\_\_\_ 6. Student's signature
- \_\_\_\_\_ 7. Parent/Guardian's signature
- \_\_\_\_\_ 8. Family Financial Affidavit