Office Use Only				
Application Approved:	☐	yes	☐	no
Amount of Award:				
Date Paid:				
Cheque Number:				

INTERPROVINCIAL SCHOOL DEVELOPMENT ASSOCIATION

ARLENE BURRIS MEMORIAL SCHOLARSHIP APPLICATION

Criteria: Awarded to:

1) a person studying in any field that will prepare them to work with students who are deaf or hard of hearing;
2) a person who is deaf or hard of hearing for post-secondary study.

Return completed application by **May 1** to:

Please return application to: **Interprovincial School Development Association**
5940 South Street, Halifax, NS B3H 2S6

PERSONAL INFORMATION:

Applicant's Name: ______________________

Permanent Address: ______________________

Postal Code: ______________________

E-Mail Address: ______________________

Telephone Number: (Home) ____________ (Work) ____________

If you are deaf or hard of hearing, please attach a recent statement from a clinical audiologist describing your hearing loss.

ACADEMIC INFORMATION:

Proposed Program of Study: ______________________

Name and Address of Education Institution:

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Year of Study: First ☐ Second ☐ Third ☐ Fourth ☐

Anticipated Date of Graduation: ______________________

Academic Average to Date: ______________________

To ensure consideration of this application, the following information must be attached:

- ☐ Transcript of academic records
- ☐ Three letters of reference (character, academic, one other)
- ☐ Evidence of acceptance into a post-secondary program
- ☐ Recent statement from a clinical audiologist describing your hearing loss (if you are deaf or hard of hearing)

Briefly describe why you need financial aid to continue your studies.

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Briefly outline your plans for your future career or profession.

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I hereby certify that the information on this application is, to the best of my knowledge, true and complete.

______________________________ ______________________________

Signature Date