



2024 Scholarship Application

Member Name: _____

Member Employer: _____

Home Street Address: _____

Home City, State, Zip: _____

Cell Phone: (____) ____-____ Work Phone: (____) ____-____

Email Address: Work _____

Home _____

Scholarship Assistance Requested for:

KAHRMM Summer Session (June)

Other, please specify _____

Requesting Tuition Cost of \$ _____

Have you already paid Tuition? Yes No

Are you a current AHRMM member? Yes No

Total Amount Requested \$ _____

Applicant's Signature

Application Date

Upon completion, email to Lori Selzer at lknoeber@kumc.edu or Lisa Feil at lfeil@amberwellhealth.org.

******To be completed by KAHRMM President and Treasurer******

Approved Denied President's Signature: _____

Check Number: _____ Check Amount: \$ _____ Date: _____

Date Check Mailed: _____ Treasurer's Signature: _____