SEIU HEALTHCARE MINNESOTA
SCHOLARSHIP PROGRAM

SON/DAUGHTER APPLICATION FORM ($500)
CECELIA RAZOOK MEMORIAL SCHOLARSHIP FORM ($1000)
(Please type or print clearly)

Name of Applicant _____

Address _____

City _____ State _____ Zip _____

Phone (Home) _____ Age _____

Name of Member _____

Member's SSN _____ Member's Employer _____

Relationship to Member _____

Please indicate how and where you would plan to use this scholarship. List the intended post-secondary institution and your educational goals. This is used for informational purposes only and does not affect eligibility. Winners are selected by lot. No academic performance standards or records required for eligibility.

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_____ _____
Applicant's Signature Date

I certify that the information contained in this application is true and that I have been a SEIU Healthcare Minnesota member in good standing for three continuous years or more as of April 30th of this year.

_____ _____
Member's Signature Date

Awards will be made payable jointly to the winners and the educational institution as indicated. Winners must use scholarship within one year of drawing date.

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