

NOTE: Dr. Gary Sears Memorial Scholarship applicants. Please complete this form, print it, sign and date, and mail to: NCSF, Inc., PO Box 296, Alliance, NE 69301

I, _____, wish to be considered for the Dr. Gary Sears Memorial Scholarship.

**I am a senior student attending _____ University
and will graduate on _____.**

I have:

**Secured employment with _____
(name of clinic)**

**in _____ . My start date is _____ .
(city) (state)**

The clinic Owner is _____ .

I accept this scholarship stipulation that should I fail to practice in the above named clinic for two years following my graduation I promise to repay the amount of this scholarship to the NVMA Centennial Scholarship foundation. I understand that the terms of the repayment will be negotiated by me and NCSF, Inc. officers and failing to reach an agreement the amount of the scholarship is payable upon demand.

Signed _____

Date _____