St. Cloud Medical Mission Scholarship Application

Deadline: August 15

Date:_______________________

Name:____

Address:____
Street City State Zip

County of Residence:_________________________

Home phone: ________________________ Cell phone: ______________________

Email Address:____

Present Occupation:____

Current Employer: ____

Address:____
Street City State Zip

Have you previously received a St. Cloud Medical Mission Scholarship: ☐ Yes ☐ No
If so, when: _____________________________________

St. Cloud Physician leading your trip: __________________ Office #:______________

Team/Destination: ____

Why do you want to go on this trip?______________________________________
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Is this trip through HELPS International? If not, what group will you be traveling with? Please include contact person, phone number and address of the organization?
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Please send completed form to: CentraCare Foundation
1406 6th Avenue North
St. Cloud, MN 56303
or email to: foundation@centracare.com
(320) 240-2810