

eraser clinic

LASER TATTOO REMOVAL

ERASER CLINIC LASER TATTOO REMOVAL SCHOLARSHIP APPLICATION

APPLICANT INFORMATION

Name: _____

Address: _____

Phone: _____

Email: _____

Date of Birth: _____ US Citizen or Resident: _____

ACADEMIC PROGRAM

College/University Name: _____

City/State: _____

Major: _____

Degree Sought: _____

Current GPA (if applicable): _____

PREVIOUS ACADEMICS

Name of Institution: _____

City/State: _____

Award Achieved: _____

Commencement Date: _____

Graduation Date: _____

GPA: _____

***** BE SURE TO INCLUDE YOUR SMALL WRITING PROJECT AND ACADEMIC TRANSCRIPT *****

Signature: _____

Date: _____