

Scholarship Certification and Permission to Release Information Form

Student ID Number (if known)

Name

Last

First

M.I.

I certify that the information provided on the Kaiser Permanente School of Allied Health Sciences Community Benefit Scholarship application (Scholarship application) is true and correct. Applicants may be required to provide verification of the information provided on the Scholarship application.

I understand that the information provided will be subject to review and my scholarship may be rescinded if the information is found to be untrue.

I give permission to Kaiser Permanente School of Allied Health Sciences (KPSAHS) to release the selected information to the recipient listed for the purpose of **evaluating my KPSAHS Community Benefit Scholarship application**.

I understand that KPSAHS and the Scholarship Committee may request additional information to verify information offered on the Scholarship Application.

AUTHORIZATION TO RELEASE

Scholarship Application – includes answers to financial need questions and essay prompts.

Academic Records – Includes academic standing, cumulative GPA earned at KPSAHS, and dates of enrollment.

By signing below, I acknowledge that KPSAHS reserves the right to seek verification of the representations made on the scholarship applications and that the applicants and recipients may be asked to provide verification documentation.

INDIVIDUAL OR CLASS OF PARTIES TO RELEASE INFORMATION TO:

- Internal Scholarship Committee (3 – 5 KPSAHS employees)
- External Scholarship Committee (3-5 individuals external to KPSAHS)

This authorization is valid through the scholarship application process for 2020.

STUDENT SIGNATURE

DATE