

**WOLVERINE DENTAL HYGIENISTS' SOCIETY**  
Detroit, Michigan



**Albreta Merritt  
Dental Hygiene  
SCHOLARSHIP AWARD APPLICATION**

*Affiliated with the National Dental Hygienists' Association • 5506 Connecticut Avenue, Suite 25 • Washington, DC 20015*

Updated Sept. 2025

**WOLVERINE DENTAL HYGIENISTS' SOCIETY**  
***ALBRETA MERRITT DENTAL HYGIENE***  
***SCHOLARSHIP AWARD APPLICATION***

- Note: A. Type or print information in black or blue ink.  
B. Answer all questions. If a section does not apply, mark "n/a."  
C. Submit a sealed official college transcript with the application. Transcripts may be mailed separately to: WDHS, P.O. Box 32286, Detroit, MI 48232.  
D. Retain a copy of the application and guidelines for your records.

NAME: \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Birthdate: MM/DD/YY Email Address \_\_\_\_\_

MAILING ADDRESS:

Street \_\_\_\_\_ Apt. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Alternate Phone Number \_\_\_\_\_

PERMANENT ADDRESS:

Street \_\_\_\_\_ Apt. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Alternate Phone Number \_\_\_\_\_

Scholarship correspondence should be mailed to which address: \_\_\_\_\_ Mailing \_\_\_\_\_ Permanent

Married: \_\_\_\_\_ Single: \_\_\_\_\_ Number of Dependents: \_\_\_\_\_

Current year/semester at Wayne County Community College District: \_\_\_\_\_

Current GPA: \_\_\_\_\_

Expected Date of Graduation \_\_\_\_\_

Residence During The School Term: On Campus \_\_\_\_\_ Off Campus Housing \_\_\_\_\_

## FINANCIAL STATUS

Please itemize in detail current financial obligations and resources.

## **OBLIGATIONS FOR EACH SEMESTER/QUARTER**

TUITION/FEES	\$ _____
INSTRUMENT FEES	\$ _____
BOOKS	\$ _____
HOUSING	\$ _____
MEALS	\$ _____
UNIFORMS	\$ _____
OTHER	\$ _____
<i>TOTAL</i>	\$ _____

## **RESOURCES FOR EACH SEMESTER/QUARTER**

EMPLOYMENT	\$ _____
SAVINGS	\$ _____
LOANS	\$ _____
SCHOLARSHIPS/GRANTS	\$ _____
PARENTS/GUARDIAN	\$ _____
GI/VA BENEFITS	\$ _____
SPOUSE	\$ _____
OTHER	\$ _____
<b><i>TOTAL</i></b>	\$ _____

## **ADDITIONAL INFORMATION**

Please use the space below to explain any special circumstances that may affect your financial status during the 20\_\_ - 20\_\_ academic year.

## AUTOBIOGRAPHICAL DATA

Submit an autobiographical statement that reflects your reasons for selecting dental hygiene as a profession. Please include any positive contributions made to your community, church, place of employment, school, etc.

## PERSONAL REFERENCE

Please list the names of those persons who have completed letters of recommendation in support of your application. The letters should be attached to this application. *Please exclude letters from family members.*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## CERTIFICATION

I certify that all information submitted with this application is true and accurate to the best of my knowledge. I understand that this application will not be considered unless it is completed, signed, dated and post-marked by May 1 of current year. I also agree to participate in the activities of the Wolverine Dental Hygienists' Society.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Please mail application to: Wolverine Dental Hygienists' Society  
c/o Albreta Merritt Scholarship Award Committee  
P. O. Box 32286  
Detroit, MI 48232

**Applications must be postmarked no later than May 1 of the current year**

---

**\*\*\*\*\*OFFICIAL USE ONLY\*\*\*\*\***

### SCHOLARSHIP CHECKLIST:

1. Completed application \_\_\_\_ 2. Official Transcript \_\_\_\_ 3. Letters of Recommendation (3) \_\_\_\_

Scholarship Approved Yes \_\_\_\_ No \_\_\_\_  
Scholarship Granted Yes \_\_\_\_ No \_\_\_\_ Amount Awarded \$ \_\_\_\_\_

If the scholarship is not granted, please provide a brief explanation:

---

---

---

Signature \_\_\_\_\_ (Scholarship Chairperson) Date: \_\_\_\_\_

Signature \_\_\_\_\_ (WDHS President) Date: \_\_\_\_\_

---

**Student Membership Application:**

Student Name: \_\_\_\_\_ Phone No. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Email address: \_\_\_\_\_ Birth Mo/Yr: \_\_\_\_\_

*Please enclose \$5.00 check for membership dues.*