



MERCY
DENTAL MISSIONS

TODAY'S DATE: ____/____/____

AGAPE SCHOLARSHIP APPLICATION FORM

First Name: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ DOB: ____/____/____

Email: _____

- Please check box if it's ok for us to use your photo to share your story
- Please check box if it is ok for us to use your first name to share your story

Printed Name: _____

Signature: _____ Date: _____ / _____ / _____

1. What is your main dental concern?

2. How long has it been since your last dental visit BEFORE MDM? _____

➢ And what did you have done? _____

3. It is our greatest desire to restore hope, health, and opportunity in our clinic.

Generous donors within and beyond Mercy Dental Missions make our scholarship awards possible. Each application is carefully reviewed, and due to the competitive nature of the program, we encourage you to share your story openly and in detail. Priority is given to the most compelling and thorough applications. Please tell us about yourself, your dental history, and how financial hardship has impacted your life and led you to postpone or neglect dental care:

...continue on back if
needed.

(MDM Use Only) Date, Award Amount, Treatment Performed, Patient Portion Invested: