



WMYSL

SCHOLARSHIP APPLICATION

PARENT NAME: _____

PLAYER NAME: _____

REQUESTED AMOUNT OF AID PER PLAYER (PLEASE CHECK ONE)

_____ I can afford to pay the Scholarship Application Fee
(*\$80 for registration before July 1 or \$100 for registration after July 1st.*)

_____ I can afford to pay more than the Scholarship Application Fee, but not the entire cost of the program.
(*\$80 for registration before July 1 or \$100 for registration after July 1st.*)

_____ I cannot afford to pay the Scholarship Application Fee nor the cost of the program due to severe
financial hardship. (*If selected, please explain your reason. Information will be kept confidential.*)

I, _____, certify that my application for scholarship is in good faith and truthfully based on financial need at present. I agree to provide documentation of my financial status in support of this application should it be requested by WMYSL.

PARENT SIGNATURE: _____

DATE: _____

Please mail this application with a check or money order of the appropriate amount made payable to "WMYSL" at the following address:

WMYSL
PO Box 84
Fairfax, CA 94978