

# Humboldt County Memorial Hospital Auxiliary Scholarship

## THE SCHOLARSHIP

Scholarship recipient is awarded (\$1000.00) per academic year with a maximum of (\$2000.00) over two academic years. You must reapply for the second year.

## TO BE ELIGIBLE YOU MUST BE

- Enrolled in an accredited health care education program.
- Have completed a minimum of two years of academic courses for a health care program (completed one year of academic courses for a 2-year health care program)
- A Humboldt County High School graduate **OR** living in Humboldt County **OR**
- Employed in a Humboldt County medical facility such as Humboldt County Memorial Hospital, medical clinic, dental office or care center.

*Indicate the program in which you are currently enrolled or to which you have been accepted.*

- Clinical Laboratory Scientist/  Nursing (Masters-MSN)  Pharmacist  Medical Technologist
- Nurse Practitioner (NP)  Physical Therapist  Clinical Laboratory Technician
- Certified Nurse Anesthetist (CRNA)  Physician Assistant  Doctor  Medical Lab Technician
- Clinical Nurse Specialist (CNS)  Respiratory Therapist  Occupational Therapist
- Nursing (LPN)  Nursing (RN)  Nurse Administrator (LISW)  Nursing (BSN)
- Ultrasound Technician  Mental Health  Other \_\_\_\_\_

Name: (Last, First, Middle Initial) \_\_\_\_\_

Maiden Name/Other Names Used: \_\_\_\_\_

Telephone # (\_\_\_\_\_) \_\_\_\_\_ Cell Phone # (\_\_\_\_\_) \_\_\_\_\_

Current Mailing Address (Street, Apt #) City, State, Zip \_\_\_\_\_

Permanent Mailing Address (Street, Apt #) City State Zip \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Where do you want scholarship correspondence sent (*check all that applies*)?

- E-mail  Current Address  Permanent Address

Parent or Guardian: \_\_\_\_\_

List the occupation(s) of all adults in your family who contribute to your financial support:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of the high school you attended: \_\_\_\_\_

Name of college/university you are attending: \_\_\_\_\_

Title of program or your major: \_\_\_\_\_

Proposed date of graduation: \_\_\_\_\_

Career Objective: \_\_\_\_\_

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List grants and/or scholarships that you have received to date and the amount of each:

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List work experiences and dates of employment:

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List school, church, and community activities. Include any offices, titles, or honors.

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List the names, addresses, and telephone numbers of **two** references that the scholarship committee may contact:

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

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On a separate sheet of paper, type a brief essay stating your reason for entering the medical field. Please include your future personal and professional goals.

List the name and the address of the person the scholarship committee may contact at your current college/university to obtain your cumulative grade point average:

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I authorize the release of the cumulative grade point average of the student named on this application.

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Student Signature

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Parent/Guardian Signature

(Required if you are living at home)

**SEND APPLICATION TO:**

**HCMH Auxiliary, 1000 N 15th Street, Humboldt, IA 50548 or  
email to [mardir@humboldthospital.org](mailto:mardir@humboldthospital.org)**

Questions? Call Mardi Ratzlaff at 515-332-4200

Application Deadline: **May 31, 2018**