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.
- Be within two years of completing a health care program (within one year of a 2-year health care program)
- Be a Humboldt County High School graduate **OR**
- Be 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
Medical Lab Technician Clinical Nurse Specialist (CNS) Respiratory Therapist
 Nursing (LPN) Nursing (RN) Nurse Administrator Social Worker (LISW)
 Nursing (BSN) Occupational Therapist Ultrasound Technician

Name: (Last, First, Middle Initial)

_____

Maiden Name/Other Names Used:

_____

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:

_____

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

_____

_____

_____

_____

_____

List work experiences and dates of employment:

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

_____

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

1._____ 2._____

_____ _____

_____ _____

_____ _____

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:

_____

_____

_____

_____

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

Student Signature

Parent/Guardian Signature

(Required if you are living at home)

IMPORTANT FILL OUT THE BELOW INFORMATION

Student ID Number: _____

(if you don't have your student ID number yet make sure to send as soon as you get it so we don't delay getting your scholarship money to your school)

Tuition Office Address/Contact

(We need this information when sending your scholarship check – the money will be placed in your student account at your school so this information is very important)

Name: _____

Address: _____ **City:** _____

State and Zip Code: _____

SEND APPLICATION TO:

HCMH Auxiliary

1000 15th St. N.

Humboldt, IA 50548

Or email to Brienne Berte at brienneb@humboldthospital.org

Application Deadline: May 31st