ProMedica Memorial Hospital Auxiliary
HEALTH EDUCATION SCHOLARSHIP

Applicant's Name: _____Home Phone #: _____

Home Address: _____

City, State, Zip _____ County: _____

If NOT Sandusky County resident, are you an employee or immediate family member of a Memorial hospital employee? ____ Yes _____ No
Relationship to employee._____

Date of Birth: _____

Marital status: Single _____ Married _____Separated _____Divorced ____

If currently attending college, your phone # there: _____
Check all that apply.

1. **What college or university do you attend or plan to attend next year? _____in _____, _____.**
   (City) (State)

2. **I _____ a) currently attend this college and am in my _____year of study.**
   _____ b) have been accepted as an undergraduate and in my healthcare program.
   _____c) have been accepted as an undergraduate but not yet eligible for my program.
   ____ d) already work in healthcare but am returning for further education.
   ____ e) have been accepted but as yet undecided where I will attend:
   Please explain: _____
   _____.

3. **I plan to major in _____, and if known, to specialize in _____.**

4. **Length of the program? _____ years. 5. Anticipated date of graduation _____**

6. **Please explain your reason for this field of study (attach separate page if needed):_____**

SCHOLASTICS:

1. **Education: What high school and any colleges or universities have you attended? Official transcripts from the most recent must be RECEIVED by March 23rd.**

School	City/State	Dates Attended (Mo. & yr.)	Anticipated Date of Graduation	Major Course of Study if college	Grade Point Average

2. **Test Scores - One or the other is required, and copy of scores must be attached. Not required if you have been out of high school more than 5 years.**

   ACT Score _____ SAT Score _____

3. **Class rank (high school) _____ out of _____.**

FINANCIAL INFORMATION:

1. **Have you applied for any scholarships besides this one? Yes ____ No _____**

   If yes, please list: _____

2. **Have you been granted any other scholarships? Yes____ No_____**

   If yes, please list:

SOURCE	AMOUNT (DESCRIBE IF ONE TIME AMOUNT OR HOW MUCH PER YEAR/HOW MANY YEARS.)
_____	_____
_____	_____

3: INCOME –

PART A – Financially dependent
Mother's name _____ Father's name _____
If parents are married to each other, annual income $_____.
Otherwise: Father's income $_____.
Mother's income $ _____.
If supported by someone other than the above, please list:
Name _____ Income * $ _____.

PART B – Financially independent
If single: * $_____.
If married: * $ _____.

PART C – All should complete.
Number and ages of dependents of the above persons, excluding yourself.
Number _____
Ages: _____, _____, _____, _____, _____, _____, _____.
Number of the above who currently attend college:_____.

4. ESTIMATED ANNUAL COST from your college brochure :

Annual tuition $_____
Annual room and board $ _____.
_____ I will live at home and commute. _____ I will live at the school.

Please provide any additional information regarding your financial need that you would like us to consider:

_____
_____
_____
_____.

ACTIVITIES (within the last FOUR years):

A) School, Community and Church
Clubs authorized and sponsored by your high school or college:

			Number of years
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Athletic teams

_____	_____	_____	_____
_____	_____	_____	_____

_____ _____ _____ _____

Musical Organization

_____ _____ _____ _____
_____ _____ _____ _____

Newspaper or Yearbook Publications **Theatre Productions**

_____ _____ _____ _____
_____ _____ _____ _____

Community organizations

_____ _____
_____ _____

Church activities

_____ _____
_____ _____

B) Leadership

Leadership positions: _____What year?_____
_____What year? _____
_____What year?_____
Student government officer: Office _____ what year? _____
Student government officer: Office _____ what year? _____
Editor of _____ what year? _____
Musical organization _____ what years? _____
Leadership position in community or church activities, please list:
_____ Year: _____
_____ Year: _____
_____ Year: _____

D) Applicant's Employment

Name of employers	Dates of employment	Job description

Statement of financial need: (This should be signed by the person contributing the major portion of your support if you are financially dependent.) "I certify that financial assistance is necessary for this applicant to complete his/her educational program."

Signature: _____ Relationship _____
Date:_____

Address if different from applicant: _____
Telephone # _____

Applicant signature: _____
Date: _____

Deadline: Applications are due no later than Friday, March 23, 2016.

Please include: Completed application, 2 reference letters, High School transcript, and ACT or SAT scores

Mail completed applications to:

ProMedica Memorial Hospital Auxiliary
Health Education Scholarship Committee
715 South Taft Avenue
Fremont, Ohio 43420

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED!