

# Ellinwood Hospital Auxiliary

# HEALTHCARE SCHOLARSHIP APPLICATION

## ELIGIBILITY

Kansas resident committed to pursuing their healthcare career in Kansas.

Part-time or full-time student in a healthcare course of study leading to a certificate, degree or credential not currently held at a Kansas educational institution, including technical, two- or four-year institution. An exception may be given for an accredited online or out-of-state program if the reason for choosing such an institution is explained in the answer to the goals question.

Attending a health care program that is accredited by their respective governing body.

Priority will be given to individuals currently residing and/or working in Ellinwood, Kansas.

## SELECTION AND AWARDS

The Auxiliary Scholarship Committee will review the applications and select the recipients. All information provided will be kept strictly confidential.

Each individual may apply annually. Limit of one award per person per year.

The scholarship will be paid directly to the educational institution, split between semesters, if applicable.

Ellinwood Hospital Auxiliary awards scholarships without regard to race, religion, creed, age, sex or national origin.

All applicants will be notified by May 30. The Auxiliary does not provide explanations regarding denials.

Awardees must fulfill the educational requirements for the academic year. If the awardee drops out or leaves his/her academic program, he/she will be expected to refund the full scholarship amount to the Auxiliary.

## APPLICATION INSTRUCTIONS

Read all instructions carefully. Complete and sign this application.

Obtain a copy of your current transcript (high school or college). Unofficial transcripts are acceptable.

Obtain two (2) letters of reference from teachers, employers, clergy, civic leaders, etc. Letters may be mailed separately; remember to remind the individuals you request reference letters from that they must be returned by **April 1**. A request form has been included in this application packet for your convenience.

Write a cover letter detailing your reasons for selecting this scholarship to apply for. Include why the Scholarship Committee should select you as the recipient of an award and your goals for the future.

Return application, transcript, and cover letter before **April 1** to:

Ellinwood Hospital Auxiliary  
c/o Scholarship Committee  
605 N Main  
Ellinwood, KS 67526

The Ellinwood Hospital Auxiliary healthcare scholarship is a competitive process and all eligible applicants will be evaluated against a standardized scoring system. All eligible applicants may not receive funding. It is the applicant's responsibility to ensure that all components of the application are complete; if a field does not apply to you and/or your situation, please write "N/A" or "Not Applicable." Incomplete or applications received after the deadline will be deemed ineligible. Please refer to the application checklist on the last page of this application form.

### APPLICANT INFORMATION

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_ Position \_\_\_\_\_

### PAST EDUCATION

High School \_\_\_\_\_ Grade \_\_\_\_\_ GPA \_\_\_\_\_

Test Scores: ACT \_\_\_\_\_ SAT \_\_\_\_\_ Other \_\_\_\_\_  
(if using another test, list type and score)

College/University \_\_\_\_\_ Year \_\_\_\_\_ GPA \_\_\_\_\_

Degree(s)/Certification(s)/Registration(s) Earned \_\_\_\_\_

Other Post-Secondary Education \_\_\_\_\_  
(if any other post-secondary education, list school, GPA, and certification(s) earned)

Academic Honors \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Extracurricular Activities \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please include any community, club, service, or religious activities in which you have been active in the past two years.

## EDUCATION GOALS

Name of School You Will be Attending \_\_\_\_\_

Accepted?  YES  NO Date Classes Begin \_\_\_\_\_  Full-Time  Part-Time

No. of General Education Credit Hours \_\_\_\_\_ No. of Program-Specific Credit Hours \_\_\_\_\_

Field of Study/Major \_\_\_\_\_

Anticipated Degree(s)/Certification(s)/Registration(s) \_\_\_\_\_

## FINANCE INFORMATION

Expected/Estimated Expenses for Academic Year:

Tuition \_\_\_\_\_ Books/Supplies \_\_\_\_\_ Living \_\_\_\_\_

Expected/Estimated Financial Assistance: (please list source and amount)

Grant(s) \_\_\_\_\_

Scholarship(s) \_\_\_\_\_

Employment \_\_\_\_\_

Family \_\_\_\_\_

Other (Loans, etc.) \_\_\_\_\_

## CERTIFICATION OF APPLICANT

I, \_\_\_\_\_, certify that the information contained in this application is true, complete, and correct to the best of my knowledge, and that all funds will be used for tuition expenses and academic fees in the current academic year.

I hereby authorize the release of personal, scholastic and financial information related to my educational status from any academic institution I have attended in the past and any academic institutions in which I am enrolled currently, to the Ellinwood Hospital Auxiliary Scholarship Program.

I  authorize  do not authorize Ellinwood Hospital Auxiliary and/or Ellinwood Hospital and Clinic to release my name, town of residence, educational institution, and course of study in press releases and online media if I am awarded the scholarship.

\_\_\_\_\_  
Date Applicant Signature

## APPLICATION CHECKLIST

Please go over these requirements and place your initials next to each requirement indicating that you have completed and attached all necessary information.

\_\_\_\_\_ Application complete – all spaces are filled. If a line is not applicable to you and/or your situation, write "N/A."

\_\_\_\_\_ If sufficient space was not provided for your information, the necessary information is continued on another sheet of paper and appropriately labeled to assist in matching answers.

\_\_\_\_\_ Transcript provided.

\_\_\_\_\_ Two reference letters are being mailed separately.

\_\_\_\_\_ Cover letter, detailing your reasons for requesting consideration for this award.

\_\_\_\_\_ Application signed and dated.

It is the applicant's responsibility to ensure that all components of the scholarship application process are complete and all required documents are received by the Auxiliary. This checklist is provided to assist the applicant. Failure to submit a completed application will result in the application being deemed ineligible.

# Ellinwood Hospital Auxiliary

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## Letter of Reference Request Form

Applicant Name \_\_\_\_\_

Reference Provided by \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_ Years Known \_\_\_\_\_

Thank you for being a mentor to the youth in our community; your involvement is needed and appreciated!

The applicant listed above has requested a letter of reference from you, as a teacher, employer, clergy member, civic leader, etc. He/She is applying to the Ellinwood Hospital Auxiliary Healthcare Scholarship program. Awards to eligible students are based on merit, involvement, and financial need.

The Ellinwood Hospital Auxiliary Scholarship Committee appreciates your time and consideration. All information will be kept confidential.

Please attach your reference and return this form, by **April 1** to:

Ellinwood Hospital Auxiliary  
c/o Scholarship Committee  
605 N Main  
Ellinwood, KS 67526