

# **SULLIVAN COUNTY MEMORIAL HOSPITAL**

*CRITICAL ACCESS HOSPITAL ♦ MHA MEMBER HOSPITAL*

630 WEST 3RD STREET  
MILAN, MO 63556  
PHONE: 660-265-4212  
FAX: 660-265-4898

February 3, 2020

High School Guidance Counselor  
Linn County R-1 School  
15533 Highway KK  
Purdin, MO 64674

Dear Counselor:

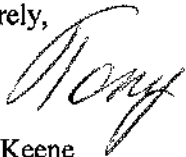
Sullivan County Memorial Hospital (SCMH) is offering up to \$1000 in scholarships again this year. Students must reside in Sullivan County and be interested in pursuing a healthcare career. The deadline to accept applications is Friday, April 10, 2020. All interested students should complete and forward a copy of the attached application to:

Tony Keene, CEO  
Sullivan County Memorial Hospital  
630 West 3<sup>rd</sup> Street  
Milan, MO 63556

Seniors pursuing a healthcare career as a registered nurse, licensed practical nurse, registered radiology technician, medical technologist, medical lab technician or physician may qualify for the scholarship. The scholarship funds will be given to awardees in January 2021, following completion of their first semester as a full-time student and a copy of their transcript to SCMH showing a GPA of 2.5 or higher. This is a one-time scholarship and is not renewable.

Senior students will be notified of a scholarship award in May 2020.

Sincerely,



Tony Keene  
Chief Executive Officer

*Equal Opportunity / Affirmative Action Employer  
services provided on a nondiscriminatory basis*

# *Sullivan County Memorial Hospital*

## **SCMH High School Scholarship Application**

Please return application to the High School Counselor prior to April 10, 2020

NAME \_\_\_\_\_  
LAST FIRST MIDDLE

ADDRESS \_\_\_\_\_  
STREET ADDRESS/ RR/ PO BOX CITY ZIP CODE

ARE YOU A RESIDENT OF SULLIVAN COUNTY? \_\_\_\_ YES \_\_\_\_ NO

PARENT/GUARDIAN NAMES:

\_\_\_\_\_  
Father Mother Phone Number

NAME OF HIGH SCHOOL \_\_\_\_\_ CITY \_\_\_\_\_

SCHOOL COUNSELORS NAME \_\_\_\_\_

G.P.A. \_\_\_\_\_ CLASS RANKING \_\_\_\_ / \_\_\_\_ (# IN CLASS) ACT SCORE \_\_\_\_\_

NUMBER OF BROTHER/SISTERS \_\_\_\_\_

HOW MANY BROTHERS/SISTERS IN COLLEGE (Secondary Education) \_\_\_\_\_

PLEASE LIST SCHOOL ACTIVITIES, HONORS, OR AWARDS YOU HAVE PARTICIPATED IN OR RECEIVED: (You may attach additional information.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST YOUR PARTICIPATION AND INVOLVEMENT IN CHURCH, COMMUNITY OR CIVIC ACTIVITIES: LETTERS OF REFERENCE MAY BE ATTACHED TO APPLICATION.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHAT UNIVERSITY, COLLEGE, TECHNICAL OR TRADE SCHOOL DO YOU PLAN TO ATTEND?

NAME OF SCHOOL/COLLEGE OR UNIVERSITY CITY STATE  
Technical School \_\_\_\_\_ College or University: \_\_\_\_\_ 1 Year \_\_\_\_\_ 2 Year \_\_\_\_\_ 4 Year \_\_\_\_\_ Other \_\_\_\_\_

Have you received a letter of acceptance from the school listed above? \_\_\_\_ Yes \_\_\_\_ No

EXPECTED COURSE OR FIELD OF STUDY? MAJOR \_\_\_\_\_ MINOR \_\_\_\_\_

PLEASE LIST YOUR FUTURE CAREER PLAN(S) INCLUDING ACADEMIC AND OCCUPATIONAL GOALS \_\_\_\_\_

DESCRIBE A BRIEF SUMMARY OF WHY YOU ARE PURSUING A MEDICAL SCIENCE OR HEALTH CARE CAREER. \_\_\_\_\_

Have you applied for other Scholarships, Grants or Financial Aid? YES \_\_\_\_ NO \_\_\_\_

IF YES, PLEASE SPECIFY:

| Name of Scholarship(s) | \$ AMT of Scholarship | Has Scholarship Been granted to you? |
|------------------------|-----------------------|--------------------------------------|
| _____                  | _____                 | _____                                |
| _____                  | _____                 | _____                                |
| _____                  | _____                 | _____                                |
| _____                  | _____                 | _____                                |

Please attach list if necessary

### **OPTIONAL QUESTIONS**

HAVE YOU OR WILL YOU APPLY FOR A STUDENT LOAN OR A GRANT WHICH WILL REQUIRE SUBSEQUENT REPAYMENT? YES \_\_\_\_ NO \_\_\_\_

HAVE YOU TAKEN A HEALTH OCCUPATIONS CLASS OR PASSED A CERTIFIED NURSING AIDE CLASS? YES \_\_\_\_ NO \_\_\_\_

ARE YOU OR YOUR PARENT(S) EMPLOYED BY SULLIVAN COUNTY MEMORIAL HOSPITAL? YES \_\_\_\_ NO \_\_\_\_

ARE YOUR PARENTS OR AN IMMEDIATE FAMILY MEMBER EMPLOYED IN HEALTHCARE? YES \_\_\_\_ NO \_\_\_\_

AFTER COLLEGE GRADUATION, DO YOU PLAN ON RETURNING TO SULLIVAN COUNTY OR RURAL AMERICA? YES \_\_\_\_ NO \_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Sullivan County Memorial Hospital sincerely appreciates your application.~  
ADDITIONAL INFORMATION MAY BE ATTACHED TO THIS APPLICATION