Public Health
Prevent. Promote. Protect.
Daviess County Health Department
609A South Main Street
Gallatin MO 64640
660-663-2414

Scholarship Application

Application due date: March 1, 2019

1. DEADLINE for scholarship applications is *March 1, 2019* (NO EXCEPTIONS)
2. Refer to application process below for a list of the supporting documents needed (i.e., reference forms, evidence of GPA, etc.) Incomplete applications will not be considered.
3. If any question does not apply to you in this application please put N/A in the space.
4. Type or print legibly. Illegible applications will be returned to you.
5. You will be notified by phone or mail in April regarding the status of your application.
6. If you have any questions about the application, contact Cheryl.Alexander@lpha.mo.gov or call her at the phone number above. The Daviess County Health Department scholarship was established in 2017. The mission of the scholarship is to provide financial assistance to individuals enrolled for undergraduate study in community colleges, trade schools and universities. The Scholarship principally targets healthcare related programs.

FINANCIAL ASSISTANCE *is based on academic performance, leadership potential, and participation in community volunteer hours.*

SCHOLARSHIP AWARDS
The Daviess County Health Department awards scholarships on the basis of a comprehensive process. Areas that are reviewed by the Board of Trustees include, but are not limited to the following: *Academic Accomplishments, Community Service, References, and Personal Essay. Scholarship funds of $1,000.00 are paid directly to the school.*

CRITERIA

- Applicants must have permanent residence in Daviess County, Missouri, *and must be a permanent resident of the United States.*
- Applicants must be completing or have completed high school successfully with a minimum unweighted GPA of 3.0 on a 4.0 scale.
- Applicants must be accepted as a full time student at a *college, university, or trade school* program for the upcoming academic semester.
- Applicants must complete and submit a Scholarship Application postmarked by Friday March 1**, 2019**
- Applicants must complete a maximum 250 word essay pertaining to a health related field.

TIMELINE

- Applications are due March 1**, 2019**
- Applicants are notified if awarded a scholarship by May 1, 2019

Application Process

SCHOLARSHIP APPLICANTS MUST PROVIDE:

- Completed application form.
- Official high school transcript in a sealed envelope from the institution.
- Two letters of recommendation.
- A maximum 250 word essay.
- A letter of acceptance from a college, university and/or a vocational, technical school.

SCHOLARSHIP AWARDS

- Award notification will be given by May 1, 2019.

Deadline for the application is Friday, **March 1, 2019**. Applications postmarked after this date will not be considered.

Please mail OR submit application to:

Daviess County Board of Trustees
ATTN: Cheryl Alexander, RN-Administrator
609A South Main Street
Gallatin, MO 64640

Application 2019-must be filled out by applicant.

Please **type or print** your answers below. A separate sheet may be used if needed. If application is illegible it will be returned to you.

1	Last Name:_____	First Name:_____
2	Mailing Address:: Street: _____ City: State: ZIP:	
3	Daytime Telephone Number: ( ) _____ Email address:_____	
4	Current High School:	High School Graduation date:
5	I will be attending the following school in the Fall of 2019: _____ Address: _____ Phone:_____	
6	Will you be a full time student? _____ (Minimum 12 hrs.)	
7	Grade Point Average (GPA): _____ (On a 4.0 scale) Attach proof of GPA; you're most recent **official** high school transcript required.	
8	ACT Score:_____ Or SAT Score: _____ A copy of your ACT **or** SAT score sheet on official high school transcript is required.	
9	Name & address of parent(s) or legal guardian(s): Use reverse side of application if you need more space. Name (s) _____ Street: _____ City:_____ State: _____ ZIP:_____ Home phone of parents or legal guardians: _____	

10	What specialty/major do you plan to major in as you continue your education?		
11	List other financial assistance you will receive per semester or quarter:		
	A.	Personal: (currently working or work /study during school)	Amount: $
	B.	Other Scholarship(s):	Amount: $
	C.	Grants:	Amount: $
	C.	Student Loan(s):	Amount: $
	D.	Other Financial Resources: (to include parent contribution)	Amount: $

Please list the following information on a separate sheet if needed.

12	**SCHOOL EXTRA-CURRICULAR ACTIVITIES:** Please list school extra-curricular activities in which you have participated. Note leadership roles and dates.
13	**References/Recommendations:** Please submit two letters of recommendations, this would not include family. Can include employers, family friends and community leaders.
14	**ORGANIZATIONS:** Please list community organizations such as service, volunteer and religious organizations in which you are now active or have previously been active. Note leadership roles and dates.
15	**RECOGNITIONS**: Please list important awards and recognitions received. Note organizations presenting honor and date.
16	**GOALS:** What are the short and long term goals for your life?
17	**NEED:** Please list your need of the Health Department Scholarship.

18	A. The following criteria must be met in order for the application to qualify to be reviewed by the Board of Trustees. B. Your application will be returned to you if these items are not attached to this application. (No exceptions.) C. Circle "YES" or "NO" to be sure you have completed and attached each item as required.		
19	YES	NO	**Application complete**
	YES	NO	**Two reference forms.** Your references should be in separate sealed envelopes
	YES	NO	**Proof of college acceptance or current student enrollment.** A letter of college enrollment or program enrollment is required for receipt of funds.
	YES	NO	**Most recent official high school or official college transcript**. Photocopies of your transcript are **not acceptable**.
	YES	NO	**250 Maximum Word Essay**

STATEMENT OF ACCURACY

I hereby affirm that all the above stated information provided by me to the Daviess county Health Department Board of Trustees is true, correct and without forgery. I also consent that my picture may be taken and used for any purpose deemed necessary to promote the Daviess County Health Department Scholarship Program.

I hereby understand that if chosen as a scholarship winner, I must provide evidence of enrollment/registration at the institution of my choice before scholarship funds can be awarded.

Signature of scholarship applicant:_____ Date: _____

The deadline for this application must be Postmarked by March 1, 2019 No exceptions!