Sullivan County Memorial Hospital

SCMH High School Scholarship Application

Please return application to the High School Counselor prior to April 13, 2018

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 Home Phone Number

NAME OF HIGH SCHOOL _____CITY _____COUNSELORS NAME_____

G.P.A._____ CLASS RANKING ____/____ (# IN CLASS) ACT SCORE _____

NUMBER OF BROTHERS/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 GRADUATION, DO YOU PLAN ON RETURNING TO SULLIVAN COUNTY OR RURAL AMERICA? YES ___ NO ___

_____ _____

Signature of Applicant Date

Sullivan County Memorial Hospital sincerely appreciates you application.~

ADDITIONAL INFORMATION MAY BE ATTACHED TO THIS APPLICATION