



# Capital Region Health Center Health Care Scholarship Application

## GENERAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Present Address: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

E-mail: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

## HIGH SCHOOL SENIORS ONLY, PLEASE COMPLETE THE FOLLOWING SECTION.

High School: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

GPA: \_\_\_\_\_

College you plan to attend: \_\_\_\_\_

Address: \_\_\_\_\_

Based on CRMC needs, have you been accepted for admission in a healthcare program in an accredited school?  Yes  No  Still Pending

Do you plan to attend:  full time  part time

Do you plan to start classes:  Fall Semester  Spring/Winter Semester

Field of Study (Major) you plan to pursue: \_\_\_\_\_

Career Goal: \_\_\_\_\_

**CURRENT COLLEGE STUDENTS AND WORKING ADULTS ONLY, PLEASE FILL OUT THIS SECTION.**

Current College: \_\_\_\_\_

College you plan to attend in the fall semester, if different: \_\_\_\_\_

Class Rank as of the Fall Semester \_\_\_\_\_ (fresh., soph., jun., sen., grad./prof.)

Major: \_\_\_\_\_

Do you plan to attend:     full time     part time

Other Education: \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title/Occupation: \_\_\_\_\_

Based on CRMC needs, have you been accepted in a healthcare program in an accredited school?  
Yes \_\_\_\_    No \_\_\_\_    Still Pending \_\_\_\_

**FINANCIAL INFORMATION**

Estimated cost of tuition per semester: \_\_\_\_\_

Please list sources and amounts of other scholarships and financial aid, and indicate if they are designated (tuition, books, room and board, etc.)

<u>Scholarship Source</u>	<u>Amount</u>	<u>Designation</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Number of immediate family members planning to attend college in the next 2 years \_\_\_\_\_

**OTHER INFORMATION**

List any school, community, or volunteer activities you are involved in: \_\_\_\_\_

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List any honors, awards, or citations you have received: \_\_\_\_\_

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Have you ever been convicted of a felony?     Yes     No

If yes, please explain: \_\_\_\_\_

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On a separate sheet of paper, submit a one-page typewritten essay of your educational goals and reasons for pursuing a health care career.

Scholarship recipients are eligible to reapply each year after receiving their initial scholarship. A new application must be submitted for each year you wish to be considered for a scholarship, including transcripts and letter from school that you are continuing in your chosen healthcare program. The scholarship must be used in the upcoming school year.

***In order for your application to be considered complete, we must receive the following:***

- Completed application form
- Complete transcript of your college career, or high school if college has not been attended
- One page essay of your educational goals and reasons for pursuing a health care career
- Letter of acceptance in an accredited school specifically stating that you have been accepted into a specific program in the health field at that school, i.e. School of Nursing, Physical Therapy, Pharmacy, MBA, etc. A letter stating that you have been accepted as a freshman at your college of choice is not acceptable.

Please return completed form to: Scholarship Committee  
c/o Valerie Weber, Manager of Senior/Volunteer Services  
Capital Region Medical Center Partners  
P.O. Box 1128  
Jefferson City, Missouri 65102

**Deadline: May 11, 2012 @ 3:00p.m.**

**Failure to meet deadline automatically eliminates your application from consideration**

By signing below, you verify that all the information is true and accurate to the best of your knowledge, and you give permission to members of the Partners Scholarship Committee to verify any information included on this form. All information is confidential and will be used only by committee members for the purpose of determining applicant's eligibility for scholarship funds.

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Applicant Signature

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Parent or Guardian Signature (if applicant is under 18)

*I verify that the information I furnished on this form is true, and I grant permission to the Partners Scholarship Committee to verify any information as necessary. I also grant Capital Region Medical Center permission to use my name and/or likeness in any media that pertains to my receipt of this scholarship.*