

MORRISON COMMUNITY HOSPITAL AUXILIARY

The Morrison Community Hospital Auxiliary scholarship is offered annually to students entering college study in a health-related field. This scholarship is given for one year but is renewable for up to four years. It will be extended to any graduates, past or present, of Morrison Community Hospital District high schools, and residing in the area. Interested applicants will be considered on their own merit.

As part of your application, please submit:

1. Three letters of reference selected from teacher, counselor, employer or clergy.
2. Profile of yourself, stressing factors relevant to your occupational choice and goals. Qualifications you feel you have to pursue your education for your chosen profession. Limit to one typewritten page.
3. An official high school transcript and available aptitude and achievement test.
4. Proof of acceptance from the educational institution you will attend.
5. Completed application given to the guidance counselor by March 15th.

Morrison Community Hospital Auxiliary Scholarship Application

Please print or type. All blanks must be completed. Use "NA" where not applicable.

Personal Information

Full Name _____

Permanent Address _____

Number

Street

City

Zip

Phone number

Birth date _____

Education Information

What is your professional goal? _____

What is your planned course of study? _____

What school will you attend this fall? _____

Expected date of graduation _____

Residence plans: Dormitory _____ Home _____ Other
specify _____

What honors (academic or otherwise) have you received and when?

Occupational Information

In what health or science related fields or activities have you been involved, for recreation, as a volunteer, or as an employee? _____

Morrison Community Hospital Auxiliary
Applicant's Name _____

List all jobs you have held (dates, employer, and type of work) and indicate whether they were full or part-time.

Employer	Duty	Dates

Confidential Information

Father's name _____

Place of employment _____

Address _____

Occupation _____

Mother's name _____

Place of employment _____

Address _____

Occupation _____

Number and ages of siblings _____

How many in school? _____

How many in college? _____

Who is the primary contributor to your support? _____

Morrison Community Hospital Auxiliary Scholarship Committee

CONSENT FOR RELEASE OF INFORMATION

“I hereby consent to the release of the above information that in the sole judgment of the Morrison Community Hospital Auxiliary Scholarship Committee may be of assistance in evaluating my scholarship application. I hereby waive any confidentiality with respect to such information in so far as the Morrison Community Hospital Auxiliary is concerned, since it is my understanding that the information will be solely for the evaluation of my application for scholarship and for no other purpose.”

Signature of Applicant _____

Print Applicant's Name _____

Date completed _____