

ALEGENT HEALTH COMMUNITY MEMORIAL HOSPITAL AUXILIARY

SCHOLARSHIP FUND GUIDELINES

(Revised 2009)

1. The fund is set up to help Harrison County persons of promising abilities discover their talents in the health field, and to help finance their education for these careers.
2. Up to seven (7) scholarships may be awarded each year to the candidates showing greatest merit and potential, the amounts to be designated each year by the scholarship committee selected by the Executive Board of the Hospital Auxiliary and announced prior to time for application.

It was decided at a meeting in 2008 to award six scholarships as follows: two (2) for \$500 each and four (4) for \$1,000 each. The \$500 scholarships are for students in a one to two-year program.

Students in their second, third and fourth years of college or training may apply for scholarships by contacting their high school counselors or writing to the chairman of the Scholarship Committee.

3. Application forms will be sent by the chairman of the Scholarship Committee to each of the high school counselors in Harrison County, and it will be the responsibility of each counselor to distribute, collect and/or make sure that all applications are returned to the scholarship chairman by the Monday preceding the April meeting of the Selection Committee. Recipients of awards will be announced and/or notified no later than May 31st of each year.
4. Any person living in Harrison County or attending a school in Harrison County, who has been accepted by an accredited institution for a program of study in the health career field shall be eligible to apply for and receive these scholarships.
5. The Scholarship Selection Committee shall consist of the Executive Board of the Auxiliary (President, Vice President, Secretary and Treasurer) or their proxies in their absence, their Scholarship Chairperson, the School Nurse and the Guidance Counselor of those Harrison County high schools that have candidates applying. The Scholarship Chairperson shall vote only in case of a tie. The secretary shall keep a record of the proceedings.

6. Employment at Alegent Health Community Memorial Hospital shall not be a requirement for application nor at any time an obligation on the part of the scholarship recipient.
7. At the end of the fall term, after January 1, the Treasurer of the Auxiliary shall send the checks for the scholarships only upon receipt of a written statement from the recipient and his/her school stating that he/she is a full time student in good standing, with a minimum of twelve (12) hours, after one complete grading period. The checks shall be made payable to the student and institution jointly. Recipients shall be informed of these conditions when notified of their selection.
8. In the event that a recipient drops out of school before completing one year or for any reason does not attend the accredited institution designated on his/her application, the money must be returned to the fund and awarded to the alternate. In cases of illness or special circumstances causing a dropout, decisions on repayment shall be left to the discretion of the Scholarship Committee.
9. The address to use in corresponding with the committee is:

Chairman, Scholarship Fund
Alegent Health Community Memorial Hospital Auxiliary
631 North 8 Street
Missouri Valley, Iowa 51555-1199
10. It is the intention of the Scholarship Committee that the scholarships be used for tuition and related expenses such as fees, books, supplies and equipment required for courses of instruction at a qualified educational organization.

**ALEGENT HEALTH COMMUNITY MEMORIAL HOSPITAL AUXILIARY
APPLICATION FOR SCHOLARSHIP**

Date: _____

Full Name: _____

Home Address: _____ Phone: _____

Present Address: _____ Phone: _____

Date of Birth: _____ Place: _____

Legal Names of Both Parents or Guardian: _____

Father's Occupation: _____ Mother's Occupation: _____

If not presently a high school student, list 3 references (former employers or adults, not relatives) who have known you well for several years.

Name	Address	Occupation

To what institution have you made application? _____ Accepted? _____

What course of study will you be pursuing? _____ No. of years? _____

Date of High School graduation: _____ Name of High School: _____

Rank in Class: _____ Size of Class: _____ Grade Point Average in High School: _____

(Please send a transcript of credits)

Have you had any post high school training to date? _____

What course of study did you pursue in high school? _____

List extracurricular activities you participated in during High School: _____

List your activities in the community or church: _____

Have you ever been employed by Community Memorial Hospital? _____ If so, when? _____

On the reverse side of this page briefly describe your educational goals and reasons for making application for this scholarship.

DECLARATION OF APPLICANT

- (1) I have read and understand the guidelines set up by the Auxiliary to determine who shall be granted the scholarships.

- (2) I understand the considerations under which scholarships are granted. I promise to use the money which may be granted to me solely for the purpose intended to pay expenses connected with my attendance at the institution mentioned on the application, and to send written notice to the committee of any change occurring in my enrollment status or home address.

Signature of Applicant _____

Date _____

DECLARATION OF PARENT OR GUARDIAN

I approve the application of my dependent for a scholarship.

Signature of Parent/Guardian _____

Spouse Signature _____

Date _____