St. Croix HEALTH
Volunteer Partners

St. Croix Health Volunteer Partners Healthcare Scholarship

TO THE APPLICANT:

By completing the information required in this application, you will enable us to determine your eligibility to receive funds provided specifically to help students planning to go on to higher education and who otherwise satisfy evaluation criteria developed by the St. Croix Health Volunteer Partners.

You must complete your sections of this application at your earliest convenience and forward it to the persons you have selected to complete the appraisal. You may select a teacher, employer, member of the clergy, a job supervisor, or any other person who is in a position to evaluate you according to the criteria given.

If any questions are not applicable to your current situation, please attach an explanatory note referring to the question and section. If more space is required for information on any items, you may attach additional information. Please indicate appropriate sections.

You are responsible for seeing that all supporting documents are submitted to St. Croix Health Volunteer Partners. Volunteer Partners reserve the right to process only applications found to be complete as of the application deadline. Completed form & recommendations must be submitted by **April 1. 2024** to:

St. Croix Health Volunteer Partners
235 E. State St.
St. Croix Falls WI 54024

REMEMBER: This application becomes valid only when all of the following pages have been submitted.

Applicant's Signature: ___________________________ Date: _______________

APPLICANT DATA (Please Print) **Application #________________**

_________________________ _____________________ _______
Name (last) (first) (m. i.)

____
Permanent Address (street) (city) (state) (zip)

__ /___ /_____ ____________________
Date of Birth Telephone Number

Name of parent/guardian____

Permanent mailing address of parent/guardian if different from applicant:

____
(street) (city) (state) (zip)

APPLICATION GUIDELINES

St. Croix Health Volunteer Partners
235 State Street * St. Croix Falls, WI 54024

PURPOSE

The scholarship fund has been established to help support individuals dedicated to pursuing a career in a health-related field. All of our scholarships are funded by donations to the Volunteer Partners, and by various designed fund raisers.

ELIGIBILITY

- Applicant must be majoring in a health-related field.
- Applicants are available to students from St. Croix Falls, Unity, Luck, Siren, Osceola, Webster and Frederic School Districts, residents of the Taylors Falls and Chisago area, and medical staff and family members of St. Croix Health.
- Incomplete applications will not be considered.

SELECTION CRITERIA

- Volunteer Service - Inside/Outside a medical facility (I.e., nursing home, senior center)
- Personal/Professional Goals
- Grade Point Average
- Financial Need
- Work Experience
- Extra-Curricular Activities
- Character Traits/References
- Quality of Application

DISTRIBUTION OF FUNDS

- Funds will be dispersed the second semester of the first year.
- Copy of transcript should be submitted to: Kathy Lucken, 713 Overlook Ct., St.Croix Falls WI 54024 ***(must be received by January 15 of the first year to receive scholarship funds)***
- Proof of registration

All applications must include the following items, or the application will not be considered:

1) **Transcript of grades**
2) **Letter of acceptance at college or vocational school and nursing program (if applicable)**
3) **Two character references**

Please use the enclosed forms when requesting character references. The references should be non-relatives, such as a teacher, employer, or co-worker. Two references must be returned by the April 1, 2024 deadline in order for the candidate to quality for consideration.

The application must be submitted to the
St. Croix Health Volunteer Partners
235 State Street
St. Croix Falls WI 54024
For further information, please call Stephanie Shobe at 608-343-9668.

St. Croix Health Volunteer Partners Healthcare SCHOLARSHIP INFORMATION

Please describe your financial need:____

____

____

Please estimate your educational costs for one year: Tuition_________________________________

Books__________________________________

Room & Board____________________________

List other resources, grants, or scholarships you have received or have applied for:_________________________

____

____

Make a statement of your plans as they relate to your educational and career objectives and further goals. Limit your answer to this space please.

____

____

____

____

____

What made you choose a healthcare profession?____________________________________

____

____

Have you received a scholarship from St. Croix Health Volunteer Partners before?

____

____

Why do you feel you deserve this scholarship?____

____

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SCHOOL DATA

School Attended: ______________________

Graduation Date: Mo.___________Yr.________

Address:____(___)__________
(street) (city) (state) (zip) Telephone No.

Name of High School Principal: ______________________________________

Name of post-secondary school(s), city, & state for which applicant's scholarship is requested. MUST HAVE!

*4 yr. College/University
*Community College
*Technical College
*Other

1. School _____________________________________

Address_____________________________________

2. School_____________________________________

Address_____________________________________

3. School_____________________________________

Address_____________________________________

Enrolled: less than half-time half-time or more full-time

Anticipated date of graduation from post-secondary program: Year ______

Major fields of study applicant has an interest in:

1. __________________________ 3.______________________________

2. __________________________ 4. ____________________________

In submitting this application, I certify that the information provided is complete and accurate to the best of my knowledge. Falsification of information may result in termination of any scholarship grant.

NOTE: Please include a letter of acceptance to a college or vocational school and nursing program (if applicable).

PERSONAL DATA

Describe your work experience during the past 4 years. Indicate months of employment in each job and approximate number of hours worked each week.

Position	Total Months Worked	Hours Per Week

PERSONAL DATA (continued)

List all school activities in which you have participated during the past **4 years** (e.g. music, sports, etc.). List all community activities in which you have participated without pay during the past **4 years** (e.g. church work, volunteer work, etc.). Indicate all special awards and/or honors. Attach extra sheet if necessary.

Activity	Years participated	Special Awards Honors	Activity	Hours participated	Special Awards Honors

APPLICANT APPRAISAL *(REQUIRED)*

You are encouraged to have this form completed by a teacher, an employer, member of the clergy, a job supervisor, or any other person who is in a position to evaluate you according to the criteria given.

You have been asked to provide information in support of this application for financial aid. Please give immediate and serious attention to the following statements. Circle the answer which best describes the individual for each. ***When complete, please return this form to the applicant, or photocopy this section and return to applicant in a sealed envelope.***

The applicant's choice of post-secondary education program is realistic:

extremely appropriate	very appropriate	moderately appropriate	inappropriate

The level of the applicant's commitment to further education is:

excellent	good	fair	poor

The applicant is able to seek, find, and use resources:

extremely well	very well	moderately well	not well

The applicant demonstrates critical thinking skills, follows through and completes tasks:

extremely well	very well	moderately well	not well

Comments (DO NOT NAME STUDENT): (*REQUIRED*)

________________________ ___________ __________________ (__)________________

Appraiser's Signature Date Title Phone number

Appraiser's business address: ________________________________

____

____

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extremely well | very well | moderately well | not well

The applicant demonstrates critical thinking skills, follows through and completes tasks:

extremely well | very well | moderately well | not well

Comments (DO NOT NAME STUDENT): (*REQUIRED*)

____________________ __________ ______________ (___)______________

Appraiser's Signature | Date | Title | Phone number

Appraiser's business address: ______________________________

____

____

TRANSCRIPT INFORMATION

All Applicants must include a transcript of grades and have the following section completed by the appropriate school official.

Applicant ranks __________ in a class of __________

Cumulative grade point average _________ / 4.0 scale

PSAT Verbal: ________ Math ________ SAT Verbal ________ Math _______

ACT Composite: ________English _______ Math _______ Science________ Reading_______

____________________________ _________________ _________ (____)___________
(School Official's Signature) (Title) (Date) (Phone)

School ____

Address ____

City, St, Zip ____

TRANSCRIPT RELEASE

Date________________________

I give my consent to release a copy of ____________________'s High School or
(Student's name)

College transcript to the St. Croix Health Volunteer Partners Scholarship Committee.

____
(Student Signature if 18 years old)

____
(Parent or Guardian's Signature, if Student is under 18 years)

PUBLICITY DISCLAIMER

I approve of publishing my name in any publication announcing my scholarship.

____________________________ ________________
(Student Signature) (Date)

STUDENT APPLICATION CHECKLIST

Please go over your application very carefully and be sure that you have all of the following items enclosed or your application will be considered incomplete and not reviewed.

________**Applicant Data Sheet – Page 1**

________**Applicant Data Sheet – Page 2**

________**St. Croix Health Volunteer Partners Healthcare Scholarship Information**

________**School Data Information Sheet**

________**Personal Data Information Sheet**

________**Include a letter of acceptance to a college or vocational school and nursing program (if applicable).**

________**Applicant Appraisal #1 in a sealed envelope**

________**Applicant Appraisal #2 in a sealed envelope**

________**Transcript Information Sheet**