ST. CROIX REGIONAL MEDICAL CENTER

Applicant I.D. #

# St. Croix Regional Medical Center, Inc.
# Scholarship Application Guidelines

**Who is eligible?** One scholarship will be granted to a graduating senior planning on going on to higher education for health care from each of the following high schools:

Chisago Lakes High School
Frederic High School
Grantsburg High School
Luck High School
Osceola High School
St. Croix Falls High School
Siren High School
Unity High School
Webster High School

**When may I apply for the scholarship?** Applications for the 2020 SCRMC Scholarship will be accepted through May 1, 2020.

**How much is awarded for the scholarship?** The scholarship is for $1,000.

**When is the scholarship awarded?** High school students receive a letter or certificate at your high school Awards Night. Students are expected to respond with a letter of acceptance with contact information, program of study and school information.

**When is the scholarship distributed?** The following January after 1st semester grades are in and student can show proof of registration for the 2nd semester.

**Questions:** Contact the Marketing and Communications Department at St. Croix Regional Medical Center at scrmc.marketing@scrmc.org for more information.

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# St. Croix Regional Medical Center, Inc.
## Scholarship Application

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 in health care.

You must complete your sections of this application and forward it to the persons you have selected to complete the character reference. You may select a teacher, employer, 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. St. Croix Regional Medical Center reserves the right to process only applications found to be complete as of the application postmark deadline. Completed form and recommendations must be submitted by April 1, 2020 to:

St. Croix Regional Medical Center
Attention: Marketing
235 State Street
St. Croix Falls, WI 54024

Needed Supporting Documents:
* Letter of acceptance at college or university
* Completed application
* No more than 250 word essay how the receiving the scholarship will help you achieve your educational goals in your chosen major in a health care field to help people live healthier, happier, and longer lives
* Character references

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

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.

Applicant's Signature: Date:

______________________________________________________________________

APPLICANT DATA

Name (Last) (First) (M.I.)

______________________________________________________________________

Permanent Address (Street) (City) (State) (Zip Code)

______________________________________________________________________

E-mail address__________________________ Mobile Phone Number (___)____________________

Name of Parent/Guardian: ______________________________________________________________

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

______________________________________________________________________

(Street) (City) (State) (Zip Code)

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Please estimate your total educational costs for one year (including your tuition, room and board, books):

Do you have any other contributions? If so, how much?

List other resources or scholarships you have received or have applied for:

**SCHOOL DATA**

High School Attended

Address (Street) (City) (State) (Zip Code) ( ) Telephone #

Graduation Date: Month/Year GPA:

Name of post-secondary school(s) for which applicant's scholarship is requested:

1.

2.

3.

- 4 Yr College University ☐
- Community College ☐
- Vo-Tech ☐
- Other ☐
- Accredited Yes ☐ No ☐

Major/field of study within healthcare the applicant plans to pursue:

1. 2.

**PERSONAL DATA**

Describe your volunteer/community involvement during the past 4 years. Indicate dates and approximate number of hours volunteered.

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List all school activities in which you have participated during the past 4 years (e.g. music, sports, etc.)
Indicate all special awards and/or honors in high school.

| Activity | Year | Awards | Activity | Year | Awards |
|---|---|---|---|---|---|
| | | | | | |
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Please list additional information on a separate sheet with your name and school district at the top.

**OTHER AWARDS**

Please list below the name and amount of any grants or scholarships that you have been awarded for the coming school year (include Pell grants, etc.):

| Name of Award | Amount | Granted | Pending |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Applicant I.D. #

I.D. #

**CHARACTER REFERENCE**

(TWO REQUIRED) This page may be photocopied

You are encouraged to have this form completed by a high school 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 in a sealed envelope.

| | | | | |
|---|---|---|---|---|
| Achievements reflect applicants ability | Extremely Well | Very Well | Moderately Well | Not Well |
| Ability to set realistic and attainable goals, is committed to his/her education | Excellent | Good | Fair | Poor |
| Commitment to school and community | Excellent | Good | Fair | Poor |
| Honesty and concern for others | Extremely Well | Very Well | Moderately Well | Poor |
| Demonstrates curiosity and initiative, problem-solving and critical thinking skills | Extremely Well | Very Well | Moderately Well | Not Well |
| Thorough, completes tasks, and is reliable | Extremely Well | Very Well | Moderately Well | Not Well |
| The applicant's respect for self and others | Excellent | Good | Fair | Poor |

Comments (Do Not Name Student):

Appraiser's Signature ___________________________ Date___________________________( ) Telephone Number

Appraiser's Business Address (street) (city) (state) (zip code)

___________________________________________________________________________

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**PERMISSION**

Permission to Publish Personal Information, Pictures and Quotes in the St. Croix Regional Medical Center
Annual Report, Displays, Promotional Videos, Media Releases, SCRMC Publications and Websites.

I (or parent/guardian if recipient is a minor) give SCRMC permission to use my picture, personal information and quote.

Name ______________________________________________ Date of Birth_________________

Name of Parent/Guardian if Minor ___________________________________________________

Email Address __________________________________ Phone Number ___________________

Address _________________________________________________________________________

Signature _____________________________________________ Date ____________________