Capital Region Medical Center
Health Care Scholarship Application

Deadline: May 6, 2020

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.

Note: High school seniors must provide proof of acceptance into a health care program at an accredited institution.

High School: ___________________________________ Graduation Year: ___________

GPA: ___________

College you plan to attend: ____

Address: ____

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 job title at CRMC: ____

If attending college:

Have you been accepted in a healthcare program in an accredited school?

☐ Yes ☐ No ☐Still Pending

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

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If pursuing a certification or continuing education:

Will you receive a certification as a result of this program? ☐ Yes ☐ No

If yes, what certification? ____

Is the certification/continuing education applicable relevant to your current job and/or beneficial to CRMC? ☐ Yes ☐ No
Please include an explanation in your essay. Manager/supervisor's signature below indicates that the program will be beneficial to CRMC.

Manager/supervisor's signature: ____

FINANCIAL INFORMATION – TO BE COMPLETED BY ALL APPLICANTS

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.)

Scholarship Source	Amount	Designation

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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____

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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 you have not attended college, with a minimum GPA of 3.2.
- One-page essay of your educational goals and reasons for pursuing a health care career
- Letter from an accredited school stating that you have been accepted into a specific program in a 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 Volunteer Services
Capital Region Medical Center Partners
P.O. Box 1128
Jefferson City, Missouri 65102

*** * * * Deadline: May 6, 2020 @ 3:00 p.m. * * * ***

Failure to meet deadline automatically eliminates your application from consideration

Required interviews for selected applicants: May 18, 2020
You will be contacted with your scheduled interview time.

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.

____
Applicant Signature

____
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.