

PARTNERS OF ST. JOSEPH'S HOSPITAL
2009 SCHOLARSHIP GUIDELINES

CRITERIA:

- 1 Must be a high school graduate or have earned a GED.
- 2 Must be accepted and enrolled in the human health care field at an accredited post-secondary school.
- 3 Permanent address of applicant must be within Chippewa County or applicant must be an employee, or child, or spouse of an employee of St. Joseph's Hospital, Chippewa Falls.
- 4 Each applicant must complete an application form along with a personal statement. Two letters of recommendation are required. One must be a teacher or an employer; the other may be from categories such as; another teacher, clergy, neighbor, law enforcement, volunteer organizations member, etc. (No family members.)
- 5 References should be asked to comment on the applicant's potential for success in the health field they plan to enter, and their character, commitment, and attitude towards health care.
- 6 Applicants must include a grade transcript from the last school year they completed.

SCHOLARSHIP AMOUNT:

The scholarship amount to be awarded is \$1,000. This is a one time, non-renewable award. Previous recipients may not apply again. The number of awards given will be determined by the funds available in the Partner's Scholarship Fund. The award check will be made payable to the recipient and the accredited post-secondary school in which he/she is enrolled .

SELECTION:

The award recipient will be chosen from those who have made application. A personal interview may be conducted.

- **Application Deadline: April 8, 2009**
- Return completed applications to the address below.

The Volunteer Office, St. Joseph's Hospital
2661 County Highway I
Chippewa Falls, WI 54729

Application for Partners of St. Joseph's Hospital Scholarship

Partners of St. Joseph's Hospital is offering a scholarship to a person who fits the Scholarship Guidelines Criteria and wishes to further his or her education in any of the human health-related fields. Members of the committee, in judging the application/s, will consider the following categories:

1. **Financial Need**
2. **Attitude toward work in health-related careers / personal statement**
3. **Community service and employment history**
4. **Recommendations (2 recommendations are required)**
5. **Record in school (GPA) and educational background**

This is a one time, non-renewable Scholarship.

Section 1 General Information

Name: Last, First, Middle Initial)	Date of Birth: ____/____/____ Month / Day / Year
Telephone Number/s: (Where reachable 9-5, M-F)	Are you an U.S. citizen?
Permanent Mailing Address:	What is your marital status as of today?(Check one) <input type="checkbox"/> single, divorced, or widowed <input type="checkbox"/> married/remarried <input type="checkbox"/> separated
If currently employed, give name and location of employer and your occupation:	

Section 2a Education History

	High School	Post Secondary Education
Name of School Attended		
City/State of School Attended		
Years Attended (Ex.'94-'98)		
Diploma/Degree		
Grade Point Average (Include Transcript)		
Detail any awards or honors received		

Section 2b Career Training / Health Educational Plans

What health career do you hope to prepare for?	What degree or certificate will you be working on in the upcoming year?
State total amount of training time required reaching your health career goal?	What will be your grade level when you begin the next school year?
Have you been accepted to the school of your choice in the next school year?	
Name and address of educational facility you plan on attending:	Are you currently in any other training program? (If yes, state program and training facility.)
Will you be attending full or part-time?	Do you attend this training full or part-time?

**Section 3
Financial Need**

What is your approximate family income?		How much money has been saved for this training?
		How much money have you saved for this training?
If married, state spouse's place of employment and occupation.		State number of dependent children in the family.
Are you a dependent of your parents?		
Mother's occupation (If living at home)	Father's Occupation (If living at home)	Number of dependents in parent's household.
Number of parent's dependent children that will be a post-secondary student in the next year.		
To what extent are your parents or spouse able to contribute to your tuition/room/board/misc. educational expenses?		
Describe impact of this scholarship on your educational plans; and/or any extenuating financial circumstances you may have.		

**Section 4
Community Service and Employment History**

What experience, if any, have you had working in a hospital, nursing home, or other health care setting?
Detail other work and/or community volunteer experience:
Detail Awards/Honors received in work or volunteer service:

**Section 5
Attitude Toward Work in Health-Related Careers / Personal Statement**

Write your personal statement on an additional sheet and attach to this application. You may share whatever you wish concerning your health career goals and your personal reasons for choosing to pursue a health career. (Please keep personal statement to one page.)

I have not been a previous recipient of the Partners of St. Joseph's Hospital Scholarship (Formerly St. Joseph's Hospital Auxiliary)

Applicant's Signature and Date

Return completed application and 2 letters of recommendation by April 8th, 2009

One reference must be a teacher or an employer. (No family members.)

Revised by the Partners Board 09/08