PIKE COMMUNITY HOSPITAL FOUNDATION
Healthcare Excellence Close To Home

SCHOLARSHIP APPLICATION FORM

100 Dawn Lane | Waverly, OH | 45690-9138 | 740-947-6311

The Pike Community Hospital Foundation offers scholarships for students pursuing a healthcare profession, in the amount of $1,000 each. Scholarships will be awarded to full-time students for the 2014-2015 academic year. Students who have previously received a scholarship from Pike Community Hospital Foundation are eligible to apply.

Application Criteria

1. Must be a U.S. Citizen or Permanent Legal Resident of the United States.

2. Must reside within Pike County.

3. Cannot be an employee of Pike Health Services, Inc. or Adena Health System; the dependent of a Pike Health Services, Inc. or Adena Health System employee; or the dependent of a Pike Health Services, Inc. or Adena Health System Board member.

4. Must be classified as a full-time applicant/student for the 2014-2015 academic year.

5. Must have financial need and be able to demonstrate the need by providing a 2012 income tax return (your own and your parents' or guardians' if you are listed as a dependent on their return). *Note: Students with other funds that cover all tuition, books, fees, and on-campus room and board are ineligible.*

6. All applications must be completed fully and postmarked or returned to the Foundation Office by **April 1, 2014,** to be eligible for consideration.

General Provisions for the Scholarship

1. Money received from the Foundation Scholarship program will be in the form of a Scholarship.

2. Scholarships will be awarded based on individual and/or family needs. Students are permitted to receive other forms of assistance or other scholarships.

3. Scholarship is for $1,000 and is considered a gift. Scholarships are not repayable nor are they renewable.

4. Scholarship money will be awarded by check in the name of the student and the school. The scholarship is for one year only, and will be paid in one (1) installment of $1,000. ***NOTE: If the student changes majors, schools, or decides not to attend school for the 2014-2015 school year, they must contact the Foundation Office. The student may or may not maintain their eligibility for the scholarship.***

Pike Community Hospital Foundation
Scholarship Application

To be eligible for consideration for a Scholarship from the Pike Community Hospital Foundation, please complete the attached application thoroughly and accurately. Return the checklist below with your application to ensure you have included all the required information.

I have included:	Included
1. A completed Scholarship application	[ ]
2. A copy of your 2012 income tax return	[ ]
3. A copy of your parents' or guardians' 2012 income tax return, if you are listed as a dependent	[ ]
4. A copy of your acceptance letter	[ ]
5. A one-page essay explaining your reason for requesting financial assistance, and why you have chosen a healthcare profession	[ ]

Please return this completed information sheet with your application.

If you have any questions or need additional information, please contact the Pike Community Hospital Foundation Office at 740-947-6311, during normal business hours.

Failure to return this completed application with supporting documentation by **April 1, 2014,** will result in ineligibility for consideration of a Scholarship from the Pike Community Hospital Foundation. Please submit your application to the address below.

Thank you for your interest in the Pike Community Hospital Foundation and good luck in your educational endeavors.

Pike Community Hospital Foundation
Scholarship Committee
100 Dawn Lane
Waverly, OH 45690

Applicant Profile

Applicant Name: _____
[Last] [First] [M.I.] [Maiden]

Home Address: _____
[Street]

_____
[City] [State] [County] [Zip]

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Family Information *(Dependent Applicants Only)*

Father's Name: _____ Occupation: _____

Address: _____ Phone: _____

Mother's Name: _____ Occupation: _____

Address: _____ Phone: _____

Parents'/Guardians' Dependents, other than yourself:

Name: _____ Age: ___ School: _____ College: ☐ Yes ☐ No

Name: _____ Age: ___ School: _____ College: ☐ Yes ☐ No

Name: _____ Age: ___ School: _____ College: ☐ Yes ☐ No

Married or Single Applicants *(Self-Supporting Applicants)*

Are you self-supporting? ☐ Yes* ☐ No
If yes, complete the following:

Are you: ☐ Single ☐ Married ☐ Divorced

Spouse's Name *(if applicable)*: _____

Spouse's Occupation/Employer: _____

List any Dependents:

_____ _____ _____
[Name] [Relationship] [Age]

_____ _____ _____
[Name] [Relationship] [Age]

Indicate all Sources of Financial Support

☐ Mother ☐ Father ☐ Spouse ☐ Self

☐ Other E*xplain:*_____

Will you be working to help meet your expenses while in school? ☐ Yes ☐ No ☐ FT ☐ PT

Explain: _____

Will you receive other scholarships, grants, and/or loans? ☐ Yes* ☐ No

***If YES, please list, including amounts on separate page.**

Employment History

_____/_____/_____/_____
Employer's Name *From* *To* *Position*

_____/_____/_____/_____
Employer's Name *From* *To* *Position*

_____/_____/_____/_____
Employer's Name *From* *To* *Position*

References

Please list the names of three individuals who you know well *(not relatives or classmates)* preferably an instructor, employer, or business person.

1) _____
Name *Address*

_____
Occupation *Phone Number*

2) _____
Name *Address*

_____
Occupation *Phone Number*

3) _____
Name *Address*

_____
Occupation *Phone Number*

Statement

Please explain your purpose for requesting financial assistance, and why you have chosen to pursue a career in a healthcare profession. Please type your statement.

Acknowledgments

The Pike Community Hospital Foundation supports the principle of equal opportunity and makes scholarship decisions without regard to race, color, religion, sex, age, national origin, ancestry, or disability. The Pike Community Hospital Foundation annually reviews the feasibility of the scholarship program, and whether or not it adequately supports the needs of Pike Community Hospital. The Foundation is under no obligation to continue this scholarship program.

Please read carefully and sign indicating your understanding.

I certify that I have read and understand all statements on this Scholarship Application and that my answers and statements are true and complete. I hereby grant permission to the Pike Community Hospital Foundation to contact my past and current educational institutions, employers, parents/guardians, and personal references to verify information I have provided and to solicit and secure other information which may be required to determine the merit of my application.

I hereby authorize any schools I have attended to furnish their records or transcripts of my grades, honors, achievements, class standing, teacher's evaluations and test results, together with all information they may have concerning me whether on record or not.

I hereby release and hold harmless all parties and persons connected with any request/release of education, employment, or other information, now or in the future, from any and all claims, liabilities, causes of action, damages and expenses of any kind for whatever reason arising out of the furnishing of information.

_____

Applicant's Signature *Date*

_____

Parent or Guardian's Signature *Date*