

Please fill in all information below. Incomplete applications will not be accepted.

All information is confidential.

PROGRAM OF STUDY

Program in which you are enrolled _____

Anticipated graduation date _____

Current year _____

APPLICANT INFORMATION

Name (Last, First, Middle Initial)

Maiden name/other names used

Telephone

Mailing address

City

State

Zip

Email address

Cell phone

Permanent mailing address

City

State

Zip

Where do you want scholarship correspondence sent? (Check all that apply) Email Current Address Permanent Address

EDUCATION

IMPORTANT: Please submit official transcripts for each secondary and post-secondary academic institution attended. If you have a GED, include the STET transcript with signature. High school transcripts are not required if proof of 24 college-credit hours with grades and GPA are sent.

High school, location

Graduation date

College/university, location

Dates attended

Hours

Graduation date

Degree earned

College/university, location

Dates attended

Hours

Graduation date

Degree earned

College/university, location

Dates attended

Hours

Graduation date

Degree earned

EMPLOYMENT AND FINANCIAL AID

Are you currently employed?

Job title:

Are you receiving any financial aid or scholarships?

If yes, please list:

Start date

Name and address of employer

Tuition

\$ _____

Room and board

\$ _____

CAREER GOALS AND ACTIVITIES

List extracurricular and community activities such as athletics, clubs, fine arts, internships, organizations and volunteering activities, beginning with the most recent. Please include dates and note leadership and other roles for each.

Why should you be selected to receive this scholarship? Use extra sheet if necessary.

Please read carefully, and sign and date the application.

- This scholarship is for students who have completed their freshman year of college. They must be studying a health care career.
- Scholarships must be used for the academic year awarded. They are not renewable. Failure to use the scholarship will result in its forfeiture unless a deferral is granted by the Great River Health System-Friends Scholarship Committee.
- Half of the scholarship is available for each semester and must be requested separately. The college or student must provide a course schedule and evidence of registration to Great River Health System-Friends each semester before funds will be released. Payments will be made directly to the college.
- **Scholarship applications must be submitted or postmarked no later than Feb. 15. Incomplete applications will not be considered.**
- **Your completed application must include all of the following:**
 - ✓ An official copy of your transcript
 - ✓ Two letters of recommendation

Mail your completed application with all required forms to:

Great River Health System-Friends
Attn: Scholarship Committee
1221 S. Gear Ave.
West Burlington, IA 52655

or email:

greatriverfriendsscholarship@gmail.com

- Scholarship recipients will be notified by April 15.
- More information about Great River Health System-Friends is available at www.greatrivermedical.org/volunteer. For questions, contact us at greatriverfriendsscholarship@gmail.com.
- If I am awarded a scholarship, I will supply a photograph. I grant permission for a publicity release that may include my name, picture, field of study and amount of my scholarship.

Applicant's signature _____ Date _____