2025 Wright Memorial Hospital Auxiliary Scholarship Checklist

Applicant Name: _____

Please attach this checklist to the front of your application and ensure that all required materials are either sent with this application or postmarked by Tuesday, April 1, 2025. **Incomplete applications will not be considered.** It is the applicant's responsibility to ensure all documents have been submitted.

Please check whether you are a:

_____ **New Applicant** *(see section **A** below)*

_____ **Previous Recipient** *(see section **B** below)*

***A. New Applicant** (and returning applicants who were not awarded a scholarship)*

_____ This checklist

_____ Completed application with essay

_____ Reference letter #1 _____ *(submitted with application or sent directly to WMH)*
Name

_____ Reference letter #2 _____ *(submitted with application or sent directly to WMH)*
Name

_____ **Letter on college/university letterhead confirming <u>full & unconditional acceptance</u> into a specific accredited 2-or 4-year college/university health care program.**

B. Previous <u>Recipient</u> of WMH Auxiliary Scholarship

_____ This checklist

_____ Completed application with essay

_____ College/University detailed transcript with classes taken & grades received

Application items may be sent as one packet or separately, but **this checklist must be completed by the student and accompany the application.** All applicants will be notified regarding the status of their application, and scholarship recipients will be invited to attend a brief ceremony (date to be determined) to receive their scholarship award.

Please contact Denise Hamilton at Wright Memorial Hospital with any questions about the scholarship, requirements, or eligibility at 660.358.5723.

SLHS will not discriminate on the basis of race, color, sexual orientation, national origin, gender identity or expression, sex, age, religion or disability in admissions or access to, or treatment or employment in, or its programs and activities.

2025 WMH AUXILIARY SCHOLARSHIP

Application Due: Tuesday, April 1, 2025

Candidates permanent address must be in the 646XX zip code, and candidate must have been accepted into an accredited 2-or 4-year college or university health care program.

A copy of the letter of full and unconditional acceptance into a specific health care program from the college or university you are attending must be attached.

I, _____ request consideration for a maximum $500.00 of financial assistance from the WMH Scholarship Fund to further my education in the field of health care. I understand I will need to reapply each year to be considered for a scholarship. I understand that I will be expected to share my grades and school status if I choose to apply for a scholarship renewal. I also understand that my eligibility for future scholarship awards is dependent upon completing my classes and receiving passing grades in each term for which I am awarded funds. If these conditions are not met, I understand I will not be eligible for further assistance for a period of one year.

_____

Last Name First Name Middle Name

_____

Street City/Town State Zip

_____ _____ Currently Employed? Y or N

Cell Phone Number Email address

_____ _____ _____

Current Employer? How Long? Approx. Gross Monthly Income

_____ _____ _____ _____

Type of Training/Degree Seeking Name of College Attending Start Date Proj. Grad. Date

Have you ever received and/or applied for the WMH Auxiliary Scholarship previously? Yes No

If so, what result did you receive and in what year:

Please list other financial assistance requested, and amount received:

Estimate of itemized costs for this semester:

Please list your involvement with community, church or school activities.
(attach additional pages as needed)

In your own words, please tell us what experience you may have had in your chosen field. Why do you wish to be funded through the WMH Auxiliary Scholarship?
(attach additional pages as needed)

All statements made in completion of the application are true and complete to the best of my knowledge. I give my permission to share any information contained herein with the Wright Memorial Hospital Auxiliary. I understand that if I am awarded a scholarship, my name and hometown will be shared in press releases and announcements.

Signed _____ Date _____

You must submit (2) two letters of recommendation from non-family members, (i.e. teacher, employer, minister, etc.) with your first application only. Send letters of recommendation and the completed application directly to:

Denise Hamilton
Wright Memorial Hospital
191 Iowa Boulevard
Trenton, Missouri 64683

Checklist, scholarship application, two letters of recommendation and copy of letter of acceptance must be received or postmarked by April 1, 2025.