

Allen County Regional Hospital (ACRH) 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 July 31 for fall semester awards and by October 31 for spring semester awards.

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

_____ Letter* of reference #1 _____ *(provide name of who the letter is received from)*

_____ Letter* of reference #2 _____ *(provide name of who the letter is received from)*

_____ Letter on institution letterhead confirming acceptance into an accredited 2 or 4 year college, university, or technical school health care program.

B. Previous Recipient of the ACRH Auxiliary Scholarship

_____ Contact with sponsor or letter requesting consideration for a second scholarship

_____ College/university detailed transcript with classes taken and grades received

Application items may be sent as one packet or separately. All applicants will be notified of receipt and of the status of their application.

*Letters of reference must be from non-family members such as a teacher, employer, minister, etc.

Please contact Kay Walker, ACRH Auxiliary Scholarship Committee Chair, with any questions about the scholarship, requirements, or eligibility. Kay can be reached at 620-228-2406 or kaywalker1234@gmail.com.

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.

ACRH AUXILIARY SCHOLARSHIP

Applications are due by July 31 (fall semester) and October 31 (spring semester).

To be eligible, candidates must have been accepted into an accredited 2 or 4 year college, university, or technical school health care program in Kansas or bordering states. Preference will be given to candidates who graduated from an Allen County high school, who currently live in Allen County, who work at Allen County Regional Hospital, or who have a parent, grandparent, or other immediate family member who works at Allen County Regional Hospital.

I, _____ request consideration for a maximum \$500.00 of financial assistance from the ACRH Auxiliary Scholarship Fund to further my education in the field of health care. I understand that I may be asked to complete an in-person or telephone interview by a member of the scholarship committee at the time of application review.

_____	_____	_____	_____
Last Name	First Name	Middle Name	
_____	_____	_____	_____
Street	City/Town	State	Zip
_____	_____	_____	_____
Mobile Phone Number	Email address	Currently Employed?	Y or N
_____	_____	_____	_____
Current Employer	How Long Employed	High School Attended	Year Graduated
_____	_____	_____	_____
Type of Training/Degree Seeking	Name of College Attending	Start Date	Proj. Graduation Date
_____	_____	_____	_____

Name of ACRH Auxiliary Sponsor

(If a sponsor is needed, please contact Kay Walker at 620-228-2406 or kaywalker1234@gmail.com and a sponsor will be assigned.)

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

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

Please tell us your reason for selecting the planned field of study, about any experience you have in the health care field, and why you chose the school you are attending.

(attach additional pages as needed)

Please tell us what community, church, or school activities you have been involved in.

(attach additional pages as needed)

Please describe any additional family or community support you receive and why you wish to be funded through the Allen County Regional Hospital 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 Allen County Regional Hospital Auxiliary. I understand that if I am awarded a scholarship, my name and hometown may be shared in press releases and announcements.

Signed _____ Date _____

Send completed application to Kay Walker at kaywalker1234@gmail.com or mail to:

**Allen County Regional Hospital
Attn: Auxiliary Scholarship Committee
P.O. Box 540
Iola, KS 66749**