# OVERVIEW & ELIGIBILITY

*The Salem Health Projects Committee (formerly Salem Health Auxiliary) Scholarship Program assists members of our community (mid- Willamette Valley) in attaining education for medical careers. Scholarships are given annually to Salem Health volunteers graduating from high school and undergraduates enrolled in medically-related programs. The monies awarded should be used to defray expenses, such as tuition, books, fees, and supplies for a medically related program, including pre-requisite coursework.*

The Scholarship Committee reviews all applications without regard to race, color, religion, national origin, sex, political affiliation, age, marital status, mental or physical disability, or sexual orientation. Applicants are evaluated on the following:

* All required items included in application packet
* Quality of application and reference letter
* Personal assessment essay of no more than one page, which should discuss:
  + extra-curricular activities
  + volunteer work/paid employment
  + choice of health care career plan
  + applicant’s financial needs and plan to fund his or her education
* GPA (grade point average)
* SAT/ACT scores for graduating high school seniors

# Eligibility:

1. You **must** be a permanent resident in any one of Marion, Polk, or Yamhill Counties or be a Salem Health employee, a spouse, or a child of a Salem Health employee, or be a high school volunteer at Salem Health.
2. You **must** be accepted to **or** have applied to a medically-related program at an accredited institution of higher education with the expectation of acceptance.
3. You must be pursuing an undergraduate degree related to a medical field.
4. High school student volunteers must meet the above qualifications and must be a current volunteer at Salem Health with a minimum of 40 hours before January 1, 2017.
5. The Projects Committee Scholarship Committee (formerly Salem Health Auxiliary) is no longer offering scholarships to postgraduate students.**\*** Postgraduate students are encouraged to apply for the Salem Health Foundation scholarship or call 503-814-1990.

# Application packets are due March 24, 2017. See page 2 for submission details.

* For the purposes of Salem Health Projects Committee activity, postgraduate means: pertaining to academic work following the award of a bachelor’s degree from a college or university; that is, work leading to a master’s or doctorate degree. A course of study following high school graduation is not postgraduate work; it is undergraduate work.

# APPLICATION WORKSHEET

Use this checklist to ensure you have a complete scholarship application packet.

# A complete application packet must include:

* A complete typed and signed copy of the application (pages 3 & 4)
* A typed essay statement addressing the required topics (page 5)
* A signed and typed, completed financial disclosure statement (page 6)
* Two (2) reference letters, completed using the form provided (page 7)
  + Reference letters may be in separate, sealed envelopes, but **must** be enclosed within the application packet for the application to be considered complete.
* School transcripts:
  + High school seniors must provide a cumulative transcript of all completed high school coursework. Provide a transcript for any college coursework completed in high school. Unofficial transcripts are acceptable.
  + College students must provide a transcript that best supports your request for funding of your medically-related course of study. Unofficial transcripts are acceptable.
* High school students must enclose SAT or ACT test results

# Submission Instructions

* 1. Application packets must be postmarked or delivered by March 24, 2017.

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| --- | --- | --- |
| Mail to: Salem Health | Hand deliver to: | Salem Health |
| Volunteer Services |  | Volunteer Office |
| Projects Committee |  | Salem Health/Building B |
| PO Box 14001 |  | 665 Winter Street SE |
| Salem, OR 97309-5014 |  | Salem, OR 97301 |

* 1. Be sure that all required items (listed above) are enclosed in your application packet. Be aware that hand-delivered application packets will not be accepted after March 24, 2017.

# ONLY COMPLETE APPLICATION PACKETS WITH ALL REQUIRED ITEMS ENCLOSED WILL BE CONSIDERED.

* 1. Questions? Leave a message with your name and phone number at 503-814-1790 and specify that your call is regarding the Projects Committee Scholarship. A scholarship committee member will return your call to assist you.
  2. All applicants will be notified of application status by the last week of May 2017.

**Application must be typed. Complete this page in full.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Applicant’s Legal Name: |  | | | | | | |
| Last First  Current Address: |  |  |  |  |  | Initial |  |
| Street & Number |  | City |  | ST |  | ZIP |  |
| Permanent Mailing Address, if different than current address: |  |  |  |  |  |  |  |
| Street & Number |  | City |  | ST |  | ZIP |  |

Home Phone: ( ) Cell Phone: ( ) Work Phone: ( )

Email:

Have you previously been awarded a scholarship from Salem Health Auxiliary? Y N

For which program are you applying for scholarship funds? (Check one)

Imaging Pre-Pharmacy Pre-Therapy

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Nursing – BSN Pre-Med Studies Sports Medicine

Nursing – RN Associate Degree Pre-requisites for:

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Other: \*

\*Please call 503-814-1790 before filling out an application to determine if your program is accepted by the Salem Health Projects Committee.

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Are you currently enrolled in this program? Y  N

Have you been accepted into the program? Y N



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If not, acceptance is expected (mm/dd/yyyy):

School you currently attend (2016-2017):

School and **medically-related program** you plan to attend in 2016-2017: (Do not abbreviate) School Name

Program

Financial Aid Office Address

How many credit hours are you currently enrolled for?

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Full time: number of credit hours per:  Quarter Semester Year Part time: number of credit hours per: Quarter Semester Year Unsure – entering as freshman and have not yet enrolled

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Year of program you will be entering:

* + 1st yr 2nd yr 3rd yr

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4th yr

Other

How many more years to complete your course of study?

Are you a high school student and Salem Health volunteer? If yes, please answer the following:



Y N



 Current Volunteer with hours in 2016-2017 Are you an employee of Salem Health? Y   N

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If yes, please answer the following:

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Current Employee

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Full Time Part Time U-Status Job Title:

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Past Volunteer

Hours worked per week:

Current Employer (if other than Salem Health): \_

**EDUCATION SUMMARY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NAME OF SCHOOL** | **YEAR/S ATTENDED** | **CREDIT HOURS** | **DEGREE/ MAJOR** | **GRADUATION OR ANTICIPATED DATE** | **GPA** |
| **HIGH SCHOOL/GED** |  |  |  |  |  |
| **COLLEGE** |  |  |  |  |  |
| **COLLEGE** |  |  |  |  |  |
| **TECHNICAL SCHOOL** |  |  |  |  |  |

**TO BE SIGNED BY ALL APPLICANTS:**

I understand that I am obligated to return monies if I should change my course of study to something other than a medically-related field. Also, should I elect to terminate my schooling, or if I have not been admitted to a medically- related program, I will forfeit any monies awarded to me. If I enroll for less than full-time credit hours, award money will be prorated accordingly.

I understand that I must provide a **copy of my letter of acceptance** into a medically-related program to the Salem Health Volunteer Services office **prior to June 30, 2017.**

I understand that in order to receive any scholarship monies I may be awarded, I must provide **in writing** the name and address of the school I will be attending, my social security number, and my student ID number (if different from my social security number) to Salem Health Projects Committee by delivering this information to the Volunteer Services Department at Salem Health **prior to June 30, 2017.**

**Applicant’s Signature Date**

# ESSAY STATEMENT

Use the space provided to type an essay describing the following:

* Employment and extra-curricular activities, including community service, as they relate to your career goals
* Your career and education plans
* Your plans for financing your education, including scholarships, employment, etc.
* A personal assessment of your strengths and weaknesses

-Essay statements written on separate paper as an addition will not be accepted.

Applicant’s Name:

# FINANCIAL DISCLOSURE STATEMENT

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Depending upon such variables as age, marital status and other circumstances, applicants may depend on family support for all or part of their education financing. If this description best fits your situation, please complete the following Dependent section and skip the Independent section*** | | | | | | | | | |
| **Dependent** | | | | | | | | | |
| Father’s Full Name | | | Occupation | | | | | Employer | |
| Mother’s Full Name | | | Occupation | | | | | Employer | |
| How many children are dependent upon your parents for support? | | | | | | | What are their ages? | | |
| Total Household Annual Income (Gross)  $ | | | | | Amount of annual financial support parents are able to provide  $ | | | | |
| ***If you are fully financially independent, please complete the Independent section below.***  ***If you are fully financially independent, but also receive assistance from your parents, please complete the Independent section below and the Dependent section above.*** | | | | | | | | | |
| **Independent** | | | | | | | | | |
| Marital Status:  Single  Married | | | | | | | | | |
| If Married, Spouse’s Full Name | | | | | | | | | |
|  | Spouse’s Occupation | | | | | | Spouse’s Employer | | |
| Number of dependents | | | | | | What are their ages? | | | |
| Total Household Annual Income (Gross)  $ | | | | Will you be receiving other financial assistance for school?   * No  Yes - if yes, please complete next section. | | | | | |
| ***All applicants must complete the Other Financial Assistance section below.*** | | | | | | | | | |
| **Other Financial Assistance** | | | | | | | | | |
| Please list all: | | Organization Name | | | | | | | Amount of Support |
| Grants | |  | | | | | | | $ |
| Scholarships | |  | | | | | | | $ |
| Employer Tuition Reimbursement | |  | | | | | | | $ |
| Other | |  | | | | | | | $ |

I certify that the information I have provided is true and correct. I will notify the Projects Committee if this information changes. I understand that the purpose of this scholarship is to defray the cost of tuition and books. I understand that I am under obligation to return the full amount of my scholarship if I change my course of study to something other than a medical or medically-related field. I understand that I am under obligation to notify the Projects Committee if my student status changes from that which is indicated on this application. I hereby authorize the release of this application and any relevant supporting information to persons involved in the selection and awarding of scholarship recipients.

Applicant's Signature Date 6

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# REFERENCE FORM

**Applicant Instructions:**

* Include **TWO (2)** current reference letters written specifically for this scholarship application
* Reference letter must be from an employer, or an instructor in your field of study
* Reference letter must be legibly handwritten or typed using this form where possible. This form can be accessed online at <http://www.salemhealth.org/scholarships>
* Reference forms must be completed by a non-family member

Name of Applicant:

**Reference Instructions:**

The above-named applicant has requested that you provide a reference for a scholarship application. The information you contribute is extremely important to the Scholarship Committee’s decision-making.

Use the check boxes and space below to provide the selection committee with evidence of this applicant’s qualifications for this scholarship. Letters without commentary severely reduce the applicant’s chances of receiving an award. Your legible and candid response is appreciated.

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|  | Above Average | Average | Below Average | N/A |
| 1. Emotional Maturity |  |  |  |  |
| 2. Work Habits |  |  |  |  |
| 3. Responsibility |  |  |  |  |
| 4. Social Interaction |  |  |  |  |
| 5. Leadership |  |  |  |  |
| 6. Academic Performance |  |  |  |  |

Signature: Date:

Name (Please Print):

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