



## 2018 Scholarship Application Instructions

The Salem Health Foundation awards scholarships to students pursuing careers in healthcare professions. Special consideration is given to applicants who are Salem Hospital employees. **Scholarships awarded will be applied to the 2018-2019 school year.**

### Qualifications:

Applicants must have a permanent residence in Marion or Polk County, be a current employee or immediate family member of a current employee at Salem Health. And, at the time of application, applicants should **be accepted into or have applied to a formal training program** in a health care field. Depending on the specific program of study, there may be one to four years of prerequisite courses to complete prior to applying for the actual program; these **prerequisite studies are not eligible for scholarship assistance**. Students must be enrolled in at least a part-time class schedule to qualify (6 cr. minimum). **Current high school seniors may apply but should be aware that priority will be given to applicants already accepted into a formal training program in a health care field.**

### Selection:

The Salem Health Foundation Scholarship Committee makes all final scholarship selections. Considerations include overall presentation and completeness of the application packet, letter of reference, academic performance, field of study, volunteer/extracurricular activities, essay and financial need. Notification will be sent by June 1, 2018.

### Instructions:

1. Applications may be printed or typed. **Incomplete application packets will not be considered.** Please contact the Foundation office at 503-814-1990 if you have any questions.
2. Email is the preferred method of submission for your completed application (**foundation@salemhealth.org**). You may either submit all documents as a single scanned PDF or you may submit the application, transcript, essay and letter of recommendation as separate documents. Please include your last name in the document title, e.g. "scholarship essay\_smith2018".
3. Completed application packets must be received in the Foundation Office\* by 4:00 p.m. on Thursday, March 29, 2018 or post-marked by March 25, 2018. Late applications will not be accepted.

#### Mailing Address:

Salem Health Foundation  
P.O. Box 14001  
Salem, OR 97309-5014

#### \*Physical Address:

Salem Health Foundation  
665 Winter Street  
Building B, First Floor  
Salem, OR 97301

### Along with the completed form, please include the following with your application:

1. A copy of your most recent college unofficial academic transcripts.
2. A typed narrative essay, not to exceed one page, on the following topic: Why should you be selected for a scholarship? Please describe any academic achievements, community service activities, examples of leadership or other personal characteristics that make you deserving of a scholarship.
3. One current and signed letter of reference from an employer or a professor in your major field, preferably on letterhead. References from family members are not accepted.
4. A current typed resume; please include paid and volunteer work experience. Resumes should be limited to two (2) pages only.

**~ If submitting a hard copy, please do not use staples when assembling your application packet. ~**

**~ Submit single sided copies ~**



## 2018 Scholarship Application

Please Type or Print Clearly

Last Name		First Name		Middle Initial	
Current Mailing Address		City		State	Zip
Permanent Street Address (if different than above)		City		State	Zip
E-mail Address			Message Phone		
Please indicate the program for which you are applying for scholarship funds: <input type="checkbox"/> Nursing - ADN <input type="checkbox"/> Pharmacy Tech - Associates <input type="checkbox"/> Imaging - Bachelors <input type="checkbox"/> Nursing - BSN <input type="checkbox"/> Pharmacist <input type="checkbox"/> Physician <input type="checkbox"/> Nursing - Advanced Practice <input type="checkbox"/> Imaging Tech - Associates <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Other*: _____					
Have you been accepted into the program? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, date acceptance is expected: _____					
School you plan to attend					
School Financial Aid Office Address ( <b>Required</b> )		City		State	Zip
Number of credit hours you will be taking per term:		Year of program you will be entering: <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input type="checkbox"/> 4 <sup>th</sup> <input type="checkbox"/> Other		Anticipated Date of Graduation Month _____ Year _____	
Are you an employee of Salem Health? <input type="checkbox"/> Current employee <input type="checkbox"/> Past employee <input type="checkbox"/> Volunteer			Do you have a family member who works for Salem Health? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, Name/Relationship to you: _____		
Position/Dept: _____			Position/Dept: _____		
Current Employer, if other than Salem Health (if applicable)		Job Title		Hours per week	
Have you received a Salem Health Foundation Scholarship in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No		If you have received a Salem Health Foundation scholarship under a different name, please list below.			
Is working at Salem Health or in the Salem community part of your career plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		How did you learn about our scholarship?			
<b>Education Summary</b>					
Name of School	Dates Attended	Credit Hours	Degree/Major	Graduation Date or Anticipated Graduation Date	GPA

**Dependent**

Do your parents claim you as a dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, complete next section)	How many children are dependent upon your parents for support?
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Total Household Annual Income (Gross) \$	Amount of annual financial support parents are able to provide to you \$
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**Independent – if your parents do NOT claim you as a dependent**

Number of dependents reliant on you	Total Household Annual Income (Gross) \$
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**Financial Assistance**

Will you receive other financial assistance for school?  No  Yes (if yes, please complete next section).

**Other Financial Assistance**

Please list all:	Organization Name	Amount of Support
Grants		\$
Scholarships		\$
Employer Tuition Reimbursement		\$
Other		\$

**Please report expenses you expect to incur for the school year – August 2018 through July 2019**

Tuition and Fees	\$	Other Directly Related School Costs	\$
Books and Supplies	\$	<b>Total Expenses</b>	\$

**Additional factors which influence your financial capabilities that you want to share with the committee:****Agreement**

I certify that the information I have provided is true and correct. I will notify the Foundation 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 Foundation 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 scholarships.

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_