

## 2019 SCHOLARSHIP APPLICATION INSTRUCTIONS

The Salem Health and Salem Health West Valley Foundations, in partnership with the Salem Health Projects Committee, award scholarships to high school and college students pursuing careers in health care professions. We give preference to applicants who are Salem Hospital or West Valley employees, their family members and Salem Health volunteers who have contributed 60+ hours. **Scholarships awarded are for the 2019-20 school year.**

### QUALIFICATIONS:

- Reside in Marion or Polk County.
  - At the time of application, **be accepted into or have applied to a formal training program** in a health care field.
  - **Prerequisite studies are only eligible for high school applicants.**
  - Plan to or currently enrolled in at least a part-time class schedule to qualify (six credit min.).
- Special consideration for:**
- Current Salem Health employee or immediate family member of a current employee.
  - Current Salem Health volunteer with a minimum 60 volunteer hours.

**SELECTION:** The Salem Health and Salem Health West Valley Foundation Scholarship Committees inform all scholarship selections. Considerations include overall presentation and completeness of the application packet, letter of reference, academic performance, field of study, volunteer/ extracurricular activities and financial need.

*We will notify all applicants by June 1, 2019.*

### INSTRUCTIONS:

1. Apply to only ONE scholarship program – Salem Health Foundation OR Salem Health West Valley Foundation.
2. Please type application.
3. **We accept only emailed applications.** Once complete, send application and required supplementary materials outlined below to [foundation@salemhealth.org](mailto:foundation@salemhealth.org).
4. Please submit completed application packets by 5 pm on Friday, March 29, 2019. Only complete, timely, emailed application packets are eligible for consideration.

### REQUIRED SUPPLEMENTARY APPLICATION MATERIALS:

1. **Academic transcripts** - A copy of your most recent high school or college **unofficial** academic transcripts.
  - A. High school students, please provide transcripts of any college course work completed in addition to your high school transcripts and ACT/SAT scores.
2. **Narrative essay** - A typed narrative essay, not to exceed 500 words: *Why should the scholarship committee select me for a scholarship?* Please share academic achievements, community service activities, examples of leadership or other personal characteristics that make you deserving of a scholarship.
3. **Resume** - A current resume, limited to two pages.
4. **Reference letter** - One current, signed letter of reference from an employer, teacher or a professor in your major field, preferably on letterhead. Reference letters may be emailed OR mailed directly to: Salem Health Foundation; Scholarship Selection; P.O. Box 1400; Salem, OR 97309-5014. This is the only part of the application we allow to be mailed. The postmark must be no later than **March 29, 2019**.

Select one scholarship: SALEM HEALTH FOUNDATION  SALEM HEALTH WEST VALLEY FOUNDATION 
**APPLICANT INFORMATION**

Last name:		First name:		Middle initial:	
Current mailing address:		City:		State:	Zip:
E-mail address:			Message phone:		
Please indicate your intended field of study:					
<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:					
Number of credit hours per term:		Year of program you will be entering:		Anticipated graduation date:	
		<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		Month/Year:	
Are you an employee or volunteer of Salem Health?			Family member <input type="checkbox"/> Current employee <input type="checkbox"/> Past		
<input type="checkbox"/> Current employee <input type="checkbox"/> Past employee			employee Name/Relationship to you:		
<input type="checkbox"/> Volunteer			Position/Dept.:		
Position/Dept.:			Position/Dept.:		
If volunteer, number of hours in 2018:					
Current employer, if other than Salem Health:			Job title:		Hours per week:
Have you received a past Salem Health Foundation or Projects Committee Scholarship?			If you received a Salem Health Foundation or Projects Committee scholarship under a different name, please list below:		
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Is working at Salem Health or in the Salem community part of your career plan?			How did you learn about our scholarship?		
<input type="checkbox"/> Yes <input type="checkbox"/> No					

**EDUCATION SUMMARY**

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' support?	
Total household annual income (Gross): \$		Amount of annual financial support parents are able to provide to you: \$	
INDEPENDENT – PARENTS DO NOT CLAIM YOU AS A DEPENDENT			
Number of dependents reliant on you:		Total household annual income (Gross): \$	
FINANCIAL ASSISTANCE			
Will you receive other financial assistance for school? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please complete next section)			
OTHER FINANCIAL ASSISTANCE			
Please list all:	Organization name	Amount of support	
Grants		\$	
Scholarships		\$	
Employer tuition reimbursement		\$	
Other		\$	
OTHER EXPENSES – Aug. 2019 through July 2020			
Tuition and fees	\$	Other school expenses	\$
Books and supplies	\$	<b>Total expenses</b>	\$
ADDITIONAL FACTORS influencing your financial capabilities for committee consideration:			
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 tuition and book expenses. Should I change my course of study to something other than a medically related field, I am obligated to return the full amount awarded.			
I will notify the Foundation if my student status changes from what I have stated on this application.			
I authorize the release of this application and any relevant supporting information to persons involved in the selection and awarding of scholarships.			
Applicant signature _____		Date _____	