CCMH AUXILIARY SCHOLARSHIP APPLICATION AND AGREEMENT

1. Name in Full: _____ Age: _____ Birthdate: _____
2. Present Address: _____
3. Telephone Number: _____ Place of Birth: _____
4. **Parents:**

   Father's Name: _____ Mother's Name: _____

   Occupation: _____ Occupation: _____

   Place of Business: _____ Place of Business: _____
5. **Siblings:**

   Names and Ages _____

   _____

   Number in High School? _____ Number in College? _____

   How many are self-supporting? _____
6. Education: What high school, junior or community college have you attended?

   School City & State Date Attended Graduation Date

   _____

   _____

   _____

   As of date of application:

   High School Rank in Class: _____ High School or College GPA: _____

   ACT Score: _____ Other pertinent test scores: _____

7. Have you applied for any other scholarships? (Please list) _____

   _____
8. What employment have you held after school and during vacation? _____

   _____

Please enclose your latest transcript of high school and/or college grades.

9. List any prizes, honors, awards you have received: _____

_____

10. List outside activities (class, community, church, etc.) _____

_____

(If necessary, and additional sheet of information pertaining to the above questions may be attached.)

11. List three references who will write a recommendation for you:

Name	**Address**	**Occupation**

(Please make sure these recommendations are send to the chairman before the application deadline, or they may accompany this application.)

12. Please develop and enclose an essay on a separate sheet giving reasons why you want to pursue a career in the health field. It may include your need for financial assistance.

13. To what school are you applying? _____

Have you been accepted? _____

REPAYMENT AGREEMENT

If I am awarded this year's scholarship by the Crawford County Memorial Hospital Auxiliary, it is my intention to complete my health career as outlines and to serve as a member of the profession for which I am preparing myself. I also agree to inform the Auxiliary of any decision to discontinue my education in any health career and I agree to repay the scholarship within six months from the date of my withdrawal.

Date: _____ Signature of Applicant: _____

Witness 1: _____ Witness 2: _____

Signature of Authorized CCMH Auxiliary member: _____

Application is due to the committee chairman by Friday, April 14, 2017.

Return Completed Application and Materials to: CCMH Auxiliary Scholarship Committee

c/o Karen Wood

100 Medical Parkway

Denison, IA 51442