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 12, 2019.

Return Completed Application and Materials to: CCMH Auxiliary Scholarship Committee
c/o Karen Wood
100 Medical Parkway
Denison, IA 51442