



# Foundation

Partner. Neighbor. Friend.

## Scholarship Application

The Salem Hospital Foundation awards scholarships to students pursuing careers in healthcare professions. Special consideration is given to applicants who are Salem Hospital employees, or will become Salem Hospital employees.

### Qualifications:

Applicants must have a permanent residence in Marion, Polk or Yamhill County (unless current employee at Salem Hospital) and at the time of the application **must be accepted into or have applied to a formal training program** in a healthcare field. Depending on the specific program of study, there may be one to two 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). **If you are currently a high school senior, please call us at 503-561-5576 before completing your application.**

### Selection:

The Salem Hospital Foundation Scholarship Committee will make all final scholarship selections. The committee will be looking at overall presentation and completeness of the application packet, letter of reference, academic performance, field of study, volunteer/extra-curricular activities and financial need. Notification of results will be sent by June 26, 2009.

### On-line Application Instructions:

1. You can print out the packet first and fill in by printing clearly on the form, or you can type into each field and print the completed form. Please read and complete the application thoroughly. You must include the attachments mentioned below. **Incomplete application packets will not be considered.** Please contact the Foundation office at 503-561-5576 if you have any questions.
2. Completed application packets **must be received in the Foundation Office\* by 5:00 p.m. on May 15, 2009 or post-marked by May 15, 2009.** No late applications will be accepted.

#### **Mailing Address:**

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

#### **\*Physical Address:**

698 12<sup>th</sup> Street SE, Suite 130  
Salem, OR 97301

3. Along with the completed form, the following must be included with your application:
  - A. Copies of most recent high school and/or college academic transcripts.
  - B. A typed one-page narrative essay; which includes a goal statement about your career aspirations and plans; brief personal assessment of your strengths and weaknesses and a description of your extra-curricular and community service activities.
  - C. One letter of reference from an employer or a professor in your major field. References from family members will not be accepted.
  - D. A current typed resume; please include paid and volunteer work experience.

Type or Print Clearly

Last Name		First Name		Middle Initial	E-mail Address		
Current Street Address				City		State	Zip
Permanent Street Address (if different than above)				City		State	Zip
Home Phone		Business Phone			Cell Phone or Message Phone		
Please indicate the program for which you are applying for scholarship funds: <input type="checkbox"/> Nursing – Associate Degree <input type="checkbox"/> Pharmacy <input type="checkbox"/> Physician <input type="checkbox"/> Nursing – BSN <input type="checkbox"/> Radiology <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nursing – MSN <input type="checkbox"/> Imaging <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Other – <b>Please call the Foundation Office at 503-561-5576 to see if your program is accepted by Salem Hospital Foundation prior to completing your application</b>							
Have you been accepted into that program? _____ If not, date acceptance is expected: _____							
School you plan to attend							
School Financial Aid Office Address				City		State	Zip
Credit Hours – complete one: Full time _____ # hrs Part time _____ # hrs		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			How many more years to complete your course of study _____		
Are you an employee of Salem Hospital? <input type="checkbox"/> Current employee <input type="checkbox"/> Past employee Position/Dept: _____				Family Member <input type="checkbox"/> Current employee <input type="checkbox"/> Past employee Name/Relationship: _____ Position/Dept: _____			
Current Employer, if other than Salem Hospital (if applicable)			Job Title		Hours worked per week		
Is working at Salem Hospital or in the Salem community part of your career plan? <span style="float: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span>							
Education Summary							
Name of School	Yrs Attended	Credit Hrs	Degree/Major	Graduation date	GPA		
High School							
College							
College							
Technical School							
Post Graduate							

Depending upon such variables as age, marital status and other circumstances, applicants may depend on parental help for all or part of their support. If this description best fits your situation, please complete the following section and skip the Independent section. If you are fully financially independent, please skip this section and continue in the section marked Independent. If both apply because you are independent, but also receiving financial assistance from your parents, please complete both sections.

**Dependent**

Father's Full Name	Occupation	Employer
Mother's Full Name	Occupation	Employer
How many children, besides yourself, 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 \$	

**Independent**

Marital Status:  Single  Married

If Married, Spouse's Full Name	Occupation	Employer
Number of dependents	What are their ages?	
Total Household Annual Income (Gross) \$	Will you be receiving 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		

**Expenses**

Tuition and Fees	\$	On campus housing	\$
Books and Supplies	\$	Off campus rent/utilities	\$
Uniforms and/or Equipment	\$	Food and Personal Expenses	\$

Other 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 scholarship recipients.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_