



Scholarship Application Instructions

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 consider overall presentation and completeness of the application packet, letter of reference, academic performance, field of study, volunteer/extracurricular activities and financial need. Notification of results will be sent by June 30, 2010.

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 items listed below along with your application form. **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 14, 2010 or post-marked by May 14, 2010.** No late applications will be accepted.

Mailing Address:

Salem Hospital Foundation
PO Box 14001
Salem, OR 97309-5014

***Physical Address:**

698 12th Street SE, Suite 130
Salem, OR 97301

3. Along with the completed form, the following must be included with your application:
 - A. Copies of your 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.

~ Please do not use staples when assembling your application packet. ~

Salem Hospital Foundation Scholarship Application

Please 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"/> Other*: _____					
* Please call the Foundation Office at 503-561-5576 to see if your program is accepted by the Salem Hospital Foundation prior to completing your application.					
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		City	State	Zip	
Credit Hours – complete one: Full time _____ # hrs Part time _____ # hrs		Year of program you will be entering: <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
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 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 – Please report expenses for the current school year

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 _____



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Partner. Neighbor. Friend.