CARLINVILLE AREA HOSPITAL AUXILIARY
SCHOLARSHIP APPLICATION
2024-2025

Before filling out this form, please read the Scholarship Application Instructions and Policies. Print carefully filling in ALL blanks using N/A where not applicable.

I. PERSONAL INFORMATION

1. Full Name_____
   Date of Birth_____

2. Present address
   Street_____
   City_____Zip_____
   Telephone_____Email_____
3. Hospital nearest your home
   Name_____City_____

II. EDUCATIONAL INFORMATION

1. What high school are you currently attending_____

2. What is your GPA through your junior year of high school?___

3. What is your class rank?_____

4. What school will you attend this fall?_____
   Full-time or part-time_____
   If part-time, specifically what else will you be doing>_____
   _____

5. What is your professional goal?_____
   _____

6. What is your course of study?_____
_____

III. SUBMIT A COMPREHENSIVE LIST OF STUDENT ACTIVITIES (Write on a separate sheet)

IV. SUBMIT A COMPREHENSIVE LIST OF VOLUNTEER AND/OR COMMUNITY ACTIVITIES. (Write on a separate sheet)

V. SUBMIT TWO LETTERS OF RECOMMENDATION. <u>One letter may be from a teacher or school administrator and one must be submitted from an adult outside the student's academic life and be a non-relative.</u>

VI. SUBMIT A TYPED ONE-PAGE ESSAY ABOUT WHY YOU WOULD LIKE TO OBTAIN AN EDUCATION IN THE MEDICAL FIELD.

If selected as the recipient of the Carlinville Area Hospital Auxiliary Scholarship, I give my permission to the Hospital Auxiliary to use my name in my application. This includes photos for publicity in the media. Yes_____No_____

I DECLARE THIS INFORMATION TO BE CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE_____

STUDENT SIGNATURE REQUIRED_____

PARENT/GUARDIAN SIGNATURE REQUIRED IF APPLICANT IS UNDER 18 YEARS OF AGE_____