|  |  |
| --- | --- |
|  | 1200 First Avenue EastSpencer, IA 51301 |

**AUXILIARY SCHOLARSHIP APPLICATION**

## Applicant Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |       |       | Date: |       |
|  | Last | First |  |  |
| Address: |       |       |
|  | Street Address | Apartment/Unit # |
|  |       |       |       |
|  | City | State | ZIP Code |
| Phone: |       | Email: |       |

## course information

|  |  |  |  |
| --- | --- | --- | --- |
| Beginning Date of Course: |       | Length of Course:  |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Date Funds Needed:  |       | Estimated Course Cost Per Semester:  | $      |

*If awarded, a check will be made out to the scholarship recipient to be used for tuition/books.*

## QUALIFICATIONS & REQUIREMENTS

**QUALIFICATIONS:** Spencer area residents enrolled in second, third or fourth year nursing or healthcare related accredited program. OR, enrollment in a short-term program or course to expand knowledge or upgrade current job skills for a Spencer Hospital employee.

**REQUIREMENTS:** To be considered, please submit the following by the announced deadline: Completed application form, proof of enrollment into the program/school where funds would be directed, personal letter briefly discussing current school or work status, community or volunteer activities and career goals along with three letters of reference.

## Education

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| High School: |       | City/State: |       |
| From: |       | To: |       | Did you graduate? |       | Diploma: |       |
|  |
| College: |       | City/State: |       |
| From: |       | To: |       | Did you graduate? |       | Degree: |       |
|  |
| Other: |       | City/State: |  |
| From: |       | To: |       | Did you graduate? |       | Degree: |       |
|  |

## Work Experience

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Company: |       | Location: |       |
| Position Held: |       | Supervisor: |       |
| Reason for Leaving: |       |
|  |
| Company: |       | Location: |       |
| Position Held: |       | Supervisor: |       |
| Reason for Leaving: |       |
|  |
| Company: |       | Location: |       |
| Position Held: |       | Supervisor: |       |
| Reason for Leaving: |       |
|  |
| Company: |       | Location: |       |
| Position Held: |       | Supervisor: |       |
| Reason for Leaving: |       |
|  |

## APPLICANT AUTHORIZATION

Please read the following statement carefully and add your signature in the space provided.

I hereby authorize investigation of all statements contained in this application. I affirm that all information contained in this document is true and complete and that any misrepresentation, falsification or willful omission herein shall be sufficient reason for refusal of scholarship. In addition, I grant Spencer Municipal Hospital Auxiliary permission to contact any previous employers listed on this application except those indicated.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |       | Date: |       |

Please return this application and requested documents to:

**Auxiliary Scholarship Committee c/o Beth Henningsen**

**Spencer Hospital, 1200 1st Avenue East**

**Spencer, Iowa 51301**

*Questions? Please contact Beth Henningsen at 712.264.8451 or* *bhenningsen@spencerhospital.org**.*