Spencer Hospital

1200 First Avenue East
Spencer, 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.