ATMORE COMMUNITY HOSPITAL AUXILIARY
Continuing Education Medical Scholarship Application
(Value - $1,000.00)

To be considered, applicants must be residents of the Atmore, Walnut Hill, Flomaton area, currently enrolled in a healthcare program at an accredited school and must have completed at least 1 year of the program in which they are enrolled. In addition, graduate and medical students may be eligible for scholarships after they have completed their undergraduate studies and have been accepted to a health related program. Previous applicants may re-apply. Complete and return this application no later than Friday, June 2, 2017 addressed to ATMORE COMMUNITY HOSPITAL AUXILIARY, Attn: SCHOLARSHIP COMMITTEE -GIFT SHOP, 401 MEDICAL PARK DRIVE, ATMORE, AL 36502. THIS COMPLETED APPLICATION, OFFICIAL TRANSCRIPTS FROM ALL COLLEGES ATTENDED TO THE PRESENT TIME AND REFERENCES ARE REQUIRED. FAILURE TO FOLLOW ALL INSTRUCTIONS OR TO GIVE ALL INFORMATION REQUESTED WILL DISQUALIFY THE APPLICATION.

PERSONAL INFORMATION

Name:________________________________ Date of Birth___________________________

Address:____

Home Phone:_________________________ Cell Phone_______________________________

Alternate contact person and phone number:____

Marital Status: ( ) Single ( ) Married) ( ) Divorced ( ) Widowed

Spouse's name and occupation:____

Number of Children:________________ Age(s):____________________________________

EDUCATION:

High School:____ Year of Graduation__________

University/College/Business School/Technical School | No. years/months | From | To

____

____

____

What are your career goals?____

____

Current activities and community involvements:______________________________

____

FINANCIAL AID:

List any sources of funding you may have at this time to help defray school expenses:

A:Scholarship____________________________________Amount $______________

B:Grant____Amount $______________

C:Loan:____Amount $ ______________

D:Other_______________________________________Amount $_______________

EMPLOYMENT:

Current
Employer:____

Address______________________________________Phone No._______________

Position/Title:___________________________Date of Employment_______________

Previous
Employer:____

Address:______________________________________Phone No._______________

Position/title____________________________Dates of Employment______________

REFERENCES: **Please have two persons (non-relatives who have known you for at least three years) mail a written and signed reference to the scholarship committee at the address listed on page 1.**

1. Name:____

Address____

Phone Number____________________Relationship:____________________________

2 Name:____

Address____

Phone Number____________________Relationship:____________________________

On a separate sheet of paper, write a short essay about your chosen profession in healthcare, including the reason for your choice, and return it with this application. Questions may be directed to:
Glenda Lowry at 251-368-4334