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

To be considered, applicants must be residents of the Atmore geographic 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 29, 2018 addressed to ATMORE COMMUNITY HOSPITAL, 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. Be sure that their address and phone number is included.

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.

If you are awarded the scholarship, you will be asked to sign the following agreement:

I understand and agree that the scholarship money will be sent directly to the college in which I am enrolled. If for any reason, after registering and being accepted in a nursing or medical related program, I fail to attend classes or withdraw, the scholarship will be revoked and I will be responsible for the return of the $1,000.00 to Atmore Community Hospital Auxiliary.

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Questions may be directed to Glenda Lowry at 251-368-4334.