**Mosaic Medical Center - Maryville Auxiliary**

**2022 Nursing & Related Medical Studies Scholarship Application**

**Application Deadline – August 26, 2022**

*The Mosaic Medical Center – Maryville Auxiliary Nursing & Related Medical Studies Scholarship program is a competitive process, and all eligible applications will be evaluated. Three scholarships will be awarded each year as funding is available.*

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| **APPLICANT INFORMATION** | | | | | |
| Last Name: | | First Name: | | Middle Initial: | |
| Maiden Name/Other Names Used: | | | SSN#: | | |
| Address: | | | Telephone (home):  ( ) | | |
| City: | State: | | Zip: | | County: |
| E-mail: | | | Telephone (cell):  ( ) | | |
| How long have you lived at your address? | | | | | |
| How did you learn about the Mosaic Medical Center – Maryville Auxiliary Scholarship?  □ Website □ Friend/Co-worker □ Past scholarship recipient □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **PROGRAM TYPE** | | | | | |
| Indicate the program in which you have been accepted in.   LPN Certificate Other Medical Studies: MD or DO Dietitian   Bachelor of Science Degree Nursing (BSN) Medical Technology (Lab) Occupational Therapy Pharmacy   Associate Degree Nursing (ADN) Physical Therapy Radiology/other Imaging Social Work   Advance Practice Nurse (APN) Speech Therapy Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| PLEASE SUBMIT AN **ORIGINAL TRANSCRIPT** WITH THIS APPLICATION FOR EACH PRIOR ACADEMIC INSTITUTION ATTENDED. IF YOU HAVE A GED, INCLUDE THE **ORIGINAL TRANSCRIPT** WITH SIGNATURE. | | | | | |
| Circle the highest grade completed: **High School:** 9 10 11 12 **GED**  **College:** 1 2 3 4 | | | | | |
| High School Attended and Location: | | | | | Graduation Date: |
| Technical/Vocational School Attended and Location: | | | Dates Attended: | | Degree Earned: |
| College/University Attended and Location: | Dates Attended/Hours: | | Graduation Date: | | Degree Earned: |
| **\*\* IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH SEPARATE SHEET. \*\*** | | | | | |

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| **ENROLLMENT VERIFICATION** | | | | |
| Name of program in which you are enrolled: | | Address: | | |
| Contact Person: | Title of Contact Person: | | | Telephone:  ( ) |
| Current Year in the Program: | Academic Year: | | Program Start Date: | Cost per semester? |
| **Applicant must show evidence of acceptance into Program  and show proof of enrollment in a Required class.** | | | | |

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| **EMPLOYMENT** | | |
| Are you currently employed?   Yes  No | Start Date: | Do you plan to remain with this employer?   Yes  No |
| If yes, name and address of employer: | | May we contact you at work?   Yes  No  Work Phone: ( ) |
| **FINANCIAL RESOURCES** | | |
| Indicate how you plan to pay expenses: (check all that may apply)   Family support  Summer earnings  Financial aid  Employment   Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Number of people in your family:  # of Adults \_\_\_\_ # of Children ­­­­­­­­­­­­­­­­\_\_\_\_, Ages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # Attending College \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Other financial considerations which need to be noted: | | |
| Please list scholarships you know you will receive: | | |
| **PERSONAL** | | |
| Please submit a resume describing your participation in school and/or community activities including a list of healthcare activities you have been involved with. Also include one letter of reference with this application. *(It is important for the selection committee to have this information from all applicants.)* | | |
| *I certify that the information contained in this application is true, complete and correct to the best of my knowledge, and that all funds will be used for educational-related expenses in the upcoming academic year. I hereby authorize the release of personal, scholastic and financial information related to my educational status from any academic institution I have attended in the past, currently attending or am currently enrolled, to the Mosaic Medical Center – Maryville Auxiliary’s Scholarship Committee.* | | |
| Signature of Applicant: | | Date: |

***APPLICATIONS MUST BE HAND DELIVERED OR POSTMARKED BY August 26, 2022.***

**INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED. QUESTIONS REGARDING THE APPLICATION AND SELECTION PROCESS SHOULD BE DIRECTED TO MOSAIC MEDICAL CENTER-MARYVILLE COMMUNITY RELATIONS OFFICE AT (660) 562-7049 or email at Kelsi.Meyer@mymlc.com.**

Completed application are to be sent to:

**Mosaic Medical Center - Maryville Hospital Auxiliary**

**Attn: Marketing & Communications Office**

**2016 South Main Street**

**Maryville, MO 64468**

**Attention: Kelsi Meyer**