**St. Francis Hospital Foundation**

**Robert J. Stoll & Lorena A. Stoll Scholarship Application**

**Application Deadline – August 26, 2022**

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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? |
| Are you eligible to work at Mosaic Medical Center - Maryville for one year following graduation?  Yes  No |
| How did you learn about the Robert J. Stoll and Lorena A. Stoll Scholarship? |
| **PROGRAM TYPE** |
| Indicate the program in which you are enrolled. LPN Certificate  Associate Degree Nursing (ADN)  Bachelor of Science Degree Nursing (BSN)  Master of Science Degree Nursing (MSN) |
| please submit a **transcript** with this application for each prior academic institution attended. if you have a ged, include that **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 Nursing 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 a nursing program and show proof of enrollment in a nursing class.** |
| **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  NoWork 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 STATEMENT** |
| **On a separate sheet, submit a personal statement describing your commitment to the profession of nursing in your community.** This statement is not to exceed one single-spaced typewritten page. **Please also attach a listing of health care activities you have been involved with.** *(It is important for the selection committee to have this information from all applicants.)* |
| ***Application must be received by August 26, 2022.***Incomplete applications will not be processed. Questions should be directed to Lisa Ewing at 660/562-7900 or via email at lisa.ewing@mymlc.com. |
| 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 current academic year. I hereby authorize the release of personal, scholastic, and financial information related to my educational status from any academic institution. I certify that I am currently enrolled in a nursing program. |
| Signature of Applicant: | Date: |

**NOTE:** The Robert J. Stoll and Lorena A. Stoll Scholarship program is a competitive process, and all eligible applications will be evaluated. Preference will be given to applicants planning to continue their career in the Maryville area. The Scholarship application must be completed in its entirety for the applicant to be eligible for consideration. Completed application should be sent to:

Lisa Ewing, Administration

Mosaic Medical Center – Maryville

2016 South Main Street, Maryville, MO 64468