St. Croix Regional Medical Center Volunteer Partners Healthcare Scholarship

TO THE APPLICANT:

By completing the information required in this application, you will enable us to determine your eligibility to receive funds provided specifically to help students planning to go on to higher education and who otherwise satisfy evaluation criteria developed by the St. Croix Regional Medical Center Volunteer Partners.

You must complete your sections of this application at your earliest convenience and forward it to the persons you have selected to complete the appraisal. You may select a teacher, employer, member of the clergy, a job supervisor, or any other person who is in a position to evaluate you according to the criteria given.

If any questions are not applicable to your current situation, please attach an explanatory note referring to the question and section. If more space is required for information on any items, you may attach additional information. Please indicate appropriate sections.

You are responsible for seeing that all supporting documents are submitted to St. Croix Regional Medical Center Volunteer Partners. SCRMC Volunteer Partners reserve the right to process only applications found to be complete as of the application deadline. Completed form & recommendations must be submitted by **April 1. 2022** to:

St. Croix Regional Medical Center Volunteer Partners
Stephanie Shobe
1977 80th Ave.
Dresser WI 54009

REMEMBER: This application becomes valid only when all of the following pages have been submitted.

Applicant's Signature: _____ Date: _____

APPLICANT DATA (Please Print) **Application #**_____

_____ _____ _____
Name (last) (first) (m. i.)

_____
Permanent Address (street) (city) (state) (zip)

__ /___ /____ _____
Date of Birth Telephone Number

Name of parent/guardian_____

Permanent mailing address of parent/guardian if different from applicant:

_____
(street) (city) (state) (zip)

APPLICATION GUIDELINES

St. Croix Regional Medical Center Volunteer Partners
235 State Street * St. Croix Falls, WI 54024

PURPOSE
The scholarship fund has been established to help support individuals dedicated to pursuing a career in a health related field. All of our scholarships are funded by donations to the Volunteer Partners, and by various designed fund raisers.

ELIGIBILITY
- Applicant must be majoring in a health related field.
- Applicants are available to students from St. Croix Falls, Unity, Luck, Siren, Osceola, Webster and Frederic School Districts, residents of the Taylors Falls and Chisago area, and medical staff and family members of St. Croix Regional Medical Center.
- Incomplete applications will not be considered.

SELECTION CRITERIA
- Volunteer Service - Inside/Outside a medical facility (I.e., nursing home, senior center)
- Personal/Professional Goals
- Grade Point Average
- Financial Need
- Work Experience
- Extra-Curricular Activities
- Character Traits/References
- Quality of Application

DISTRIBUTION OF FUNDS
- Funds will be dispersed the second semester of the first year.
- Copy of transcript should be submitted to: Kathy Lucken, 713 Overlook Ct., St.Croix Falls WI 54024 ***(must be received by January 15 of the first year to receive scholarship funds)***
- Proof of registration

All applications must include the following items or the application will not be considered:
1) **Transcript of grades**
2) **Letter of acceptance at college or vocational school and nursing program (if applicable)**
3) **Two character references**

Please use the enclosed forms when requesting character references. The references should be non-relatives, such as a teacher, employer or co-worker. Two references must be returned by the April 1, 2022 deadline in order for the candidate to quality for consideration.

The application must be submitted by mail to the
St. Croix Regional Medical Center Volunteer Partners and addressed to:
Volunteer Coordinator, SCRMC Volunteer Partners, 1977 80th Ave., Dresser WI 54009.
For further information, please call Stephanie Shobe at 608-343-9668.

SCRMC Volunteer Partners Healthcare SCHOLARSHIP INFORMATION

Please describe your financial need:_____

_____

_____

Please estimate your educational costs for one year: Tuition_____

Books_____

Room & Board_____

List other resources, grants or scholarships you have received or have applied for:_____

_____

_____

Make a statement of your plans as they relate to your educational and career objectives and further goals. Limit your answer to this space please.

_____

_____

_____

_____

_____

What made you choose a healthcare profession?_____

_____

_____

Have you received a scholarship from St. Croix Regional Medical Center Volunteer Partners before?

_____

_____

Why do you feel you deserve this scholarship?____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SCHOOL DATA

School Attended: _____

Graduation Date: Mo._____Yr._____

Address:_____(___)_____
(street) (city) (state) (zip) Telephone No.

Name of High School Principal: _____

Name of post-secondary school(s), city, & state for which applicant's scholarship is requested. MUST HAVE!

1. School _____
   Address_____

2. School_____
   Address_____

3. School_____
   Address_____

*4 yr. College/University
*Community College
*Technical College
*Other

Enrolled: less than half-time half-time or more full-time

Anticipated date of graduation from post-secondary program: Year _____

Major fields of study applicant has an interest in:

1. _____ 3._____

2. _____ 4. _____

In submitting this application, I certify that the information provided is complete and accurate to the best of my knowledge. Falsification of information may result in termination of any scholarship grant.

NOTE: Please include a letter of acceptance to a college or vocational school and nursing program (if applicable).

PERSONAL DATA

Describe your work experience during the past 4 years. Indicate months of employment in each job and approximate number of hours worked each week.

Position	Total Months Worked	Hours Per Week

PERSONAL DATA (continued)

List all school activities in which you have participated during the past **4 years** (e.g. music, sports, etc.) List all community activities in which you have participated without pay during the past **4 years** (e.g. church work, volunteer work, etc.) Indicate all special awards and/or honors. Attach extra sheet if necessary.

Activity	Years participated	Special Awards Honors	Activity	Hours participated	Special Awards Honors

APPLICANT APPRAISAL (*REQUIRED)*

You are encouraged to have this form completed by a teacher, an employer, member of the clergy, a job supervisor, or any other person who is in a position to evaluate you according to the criteria given.

You have been asked to provide information in support of this application for financial aid. Please give immediate and serious attention to the following statements. Circle the answer which best describes the individual for each. ***When complete, please return this form to the applicant, or photocopy this section and return to applicant in a sealed envelope.***

The applicant's choice of post-secondary education program is realistic:

extremely appropriate | very appropriate | moderately appropriate | inappropriate

The level of the applicant's commitment to further education is:

excellent | good | fair | poor

The applicant is able to seek, find, and use resources:

extremely well | very well | moderately well | not well

The applicant demonstrates critical thinking skills, follows through and completes tasks:

extremely well | very well | moderately well | not well

Comments (DO NOT NAME STUDENT): (*REQUIRED*)

_____ _____ _____ (___)_____

Appraiser's Signature | Date | Title | Phone number

Appraiser's business address: _____

_____

_____

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Comments (DO NOT NAME STUDENT): (*REQUIRED*)

_____ _____ _____ (___)_____

Appraiser's Signature | Date | Title | Phone number

Appraiser's business address: _____

_____

_____

TRANSCRIPT INFORMATION

All Applicants must include a transcript of grades and have the following section completed by the appropriate school official.

Applicant ranks _____ in a class of _____

Cumulative grade point average _____ / 4.0 scale

PSAT Verbal: _____ Math _____ SAT Verbal _____ Math _____

ACT Composite: _____English _____ Math _____ Science_____ Reading_____

_____ _____ _____ (____)_____
(School Official's Signature) (Title) (Date) (Phone)

School _____
Address _____
City, St, Zip _____

TRANSCRIPT RELEASE

Date_____

I give my consent to release a copy of _____'s High School or
(Student's name)

College transcript to the St. Croix Regional Medical Center Volunteer Partners Scholarship Committee.

_____
(Student Signature if 18 years old)

_____
(Parent or Guardian's Signature, if Student is under 18 years)

PUBLICITY DISCLAIMER

I approve of publishing my name in any publication announcing my scholarship.

_____ _____
(student signature) (date)

STUDENT APPLICATION CHECKLIST

Please go over your application very carefully and be sure that you have all of the following items enclosed or your application will be considered incomplete and not reviewed.

_____Applicant Data Sheet – Page 1

_____Applicant Data Sheet – Page 2

_____SCRMC Volunteer Partners Healthcare Scholarship Information

_____School Data Information Sheet

_____Personal Data Information Sheet

_____Include a letter of acceptance to a college or vocational school and nursing program (if applicable).

_____Applicant Appraisal #1 in a sealed envelope

_____Applicant Appraisal #2 in a sealed envelope

_____Transcript Information Sheet