

Effingham Health System Auxiliary Scholarship Fund

Application must be submitted with all documentation by APRIL 9, 2024.
Year 2024-2025

The award amount is \$500 to \$1000.

Completed application to: Rosemary Alexander, 110 Laurel Pointe Dr., Springfield,
GA 31329 (912) 604-9616 or School Counselor (Must include all documents.)

You must meet these qualifications and turn in all paperwork with your application.

- Have a 3.0 GPA
- Include a letter of acceptance from a college (or copy of your application) offering a program of study leading to a medical career. Keep your original acceptance letter and provide a copy only.)
- You can apply if you plan to go to a technical school, 2 year or 4 year school, are at least a high school senior or in college.
- Write an autobiographical sketch including your plans for a health field career.
- Submit a photograph of any size.
- Must be a resident of Effingham County.
- Include three written/signed letters of recommendation. Recommendations must be in a sealed envelope and cannot be from personal friends or family.
- Show evidence of financial need in pursuance of a career in the medical field. All information is confidential and destroyed when awards are determined.
- Include an official high school transcript or college transcript, if applicant is in college. Transcripts must be in a sealed envelope.

**Effingham Health System Auxiliary Scholarship Application
2024-2025**

Personal Information:

Full Name _____

Last four Digits of Security Number _____ Birth Date _____

Home Address _____

City _____ Zip _____

Parent(s) Telephone _____

Your Cell Telephone _____ Your E-mail _____

What **College** do you plan to attend? _____

College Full Address _____

Education Information:

What is your professional goal? _____

Have you had a conversation with someone in your field of interest? _____

Have you shadowed or been in a workplace in your field of interest? _____

Will you attend school ___ Full Time ___ Part Time _____

What Honors (academic or otherwise) have you received: _____

What other scholarships have you applied for: _____

Occupational Information:

In what health or science related fields or activities have you been involved in for recreation or as a volunteer? _____

List all jobs you have held and indicated whether they were full time or part time.
Paid work and volunteer work can be listed.

<u>Employer</u>	<u>What kind of work did you do?</u>	<u>Dates</u>
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Confidential Information: Family Income from ALL sources.

Father's Name _____

Employer _____

Occupation and Income _____

Mother's Name _____

Employer _____

Occupation and Income _____

List any other income _____

Age of Siblings _____

How many in school? _____ How many in college? _____

Does family contribute to the support of any other person(s)? _____

Student Certification:

I declare that the information reported is true, correct and complete.

Signature _____ Date _____

Scholarship Agreement:

It is agreed that:

1. The decision of the Scholarship Committee's award is final.
2. Further personal and/or financial information will be provided to the committee if requested.
3. In the event the student does not start school or ceases course of study in related health field, the scholarship funding will not apply and therefore the award will not be paid.
4. If the award check is not cashed within thirty (30) days of receipt the check will be canceled and the award withdrawn.

**Student and parent(s) have read
and clearly understand the above agreement.**

This, the _____ day of _____, 20____.

Student Signature _____

Parent(s) or Guardian(s)

Signature _____

**The deadline for this application and all documentation is
APRIL 9, 2024 (No late applications will be accepted.)**