

THE AUXILIARY OF MEMORIAL MEDICAL CENTER

ANNOUNCEMENT

The Auxiliary of Memorial Medical Center
2014 Healthcare Scholarship Applications are now available

The Auxiliary of Memorial Medical Center Scholarship Committee is accepting applications for its 2014 Healthcare Scholarship(s).

The scholarship totaling \$5,000 will be awarded to an individual or individuals currently pursuing a career in healthcare. The recipient(s) will be selected based upon financial need and academic achievement.

Eligibility for a scholarship includes the following:

- Applicant or applicant's family member must currently be a Memorial Medical Center employee or volunteer.
- Applicant must have successfully completed at least one year of an undergraduate or graduate healthcare related program.
- Completed application packets must be returned to the Scholarship Committee **no later than July 15, 2014.**

Award recipient(s) will be notified by August 31, 2014.

If you or someone you know is eligible for this scholarship go to one of the following locations to get an application:

The Little Shop on the 3rd floor Main Campus

Conemaugh School of Nursing

University of Pittsburgh at Johnstown – Financial Aid Office

St. Francis University – Financial Aid Office

Mount Aloysius College – Financial Aid Office

For additional information, contact the Auxiliary Office at 814-534-5985

THE AUXILIARY OF MEMORIAL MEDICAL CENTER (MMC)
2014 HEALTHCARE SCHOLARSHIP(S)

The Auxiliary of Memorial Medical Center would like to assist an individual(s) seeking a career in the healthcare field to attain his/her goal. We are offering scholarship award(s), totaling \$5,000 for the 2013-2014 academic year. The recipient(s) will be selected based upon financial need, academic achievement, essay, and personal interview for the three finalists.

To be eligible:

- Applicant or immediate family member of applicant must currently be a Memorial Medical Center employee or volunteer. **Immediate** is defined as Mother, Father, Brother, Sister, Spouse, Child, Grandparents, Step-Mother, Step-Father, Step-Sibling. **MMC** includes CPG.
- Applicant must have successfully completed at least one year in an accredited undergraduate or graduate healthcare related program.
- Undergraduate applicants must have a total GPA of 2.5 or greater.
- Graduate applicants must have a total GPA of 3.5 or greater.

In order to assure all materials are received on time and to be considered for this scholarship, the APPLICANT must submit the complete application packet including all REQUIRED documents to the AUXILIARY OFFICE no later than July 15, 2014.
Late or incomplete applications will not be considered.

Use the check boxes to assure you have gathered the required documentation:

- Completed Application form completed by applicant
- Completed Financial Need form completed by school financial aid officer.
- OFFICIAL transcripts of academic records with the latest grading period and cumulative GPA. Submit in sealed envelop from school (no copies or faxes will be accepted).
- Essay of no more than one page describing your personal history, career goals, and most importantly, how this monetary award will help you achieve your career goals.
- Two letters of character references, one from a current faculty member and one that is work related, if possible. Family members or relatives can not give references. Please include mailing addresses and phone numbers of references.
References may be contacted if applicant is a finalist.

A student is eligible to reapply for this scholarship as long as need and academic standing are maintained. Prior recipients are ineligible for this scholarship.

For more information or to ask questions, call the Auxiliary office at 814.534.5985 and leave a message for the Scholarship Chairperson.

Please mail or deliver your application packet to: Auxiliary of Memorial Medical Center
Attention: Scholarship Committee
Conemaugh Memorial Medical Center
1086 Franklin Street
Johnstown, PA 15905

THE AUXILLARY OF MEMORIAL MEDICAL CENTER (MMC)
2014 HEALTHCARE SCHOLARSHIP(S)

APPLICANT DATA (type or print legibly)

FULL NAME _____

(first, middle, last)

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ SS# _____

TELEPHONE: HOME _____ CELL _____

My affiliation with MMC: Employee: _____ Volunteer: _____

Family Member Employee: _____ Family Member Volunteer: _____

*****Relationship of family member to applicant:***

Mother _____ Father _____ Brother _____ Sister _____ Spouse _____ Child _____

Grandparents _____ Step-Mother _____ Step-Father _____ Step-Sibling _____

If applicant is employee: Facility _____ Department _____

Position _____

If applicant is a volunteer: Facility _____ Department _____

Responsibilities: _____

If family member is employee: Facility _____ Department _____

Position _____

If family member is a volunteer: Facility _____ Department _____

Responsibilities _____

Name of Family Member: _____

Other relevant information: _____

NOTES:

1. Please do not leave any questions unanswered. If question does not apply, write "N/A" (not applicable).
2. If more space is needed to thoroughly answer a question, attach a separate sheet of paper.
3. The top three finalists will be contacted for a personal interview with the Committee.

ACADEMIC ACHIEVEMENT

Name of current healthcare program: _____

Name of College/University/Professional School/2 year Technical School: _____

Address of School: _____

Length of Program: _____

Number of years completed: One ___ Two ___ Three ___ Four ___ Five ___ Six ___

Number of credits earned: _____ Cum GPA: _____ Expected graduation date: _____

Number of years remaining to complete the program: _____

What professional goals do you plan to achieve when you earn your degree/diploma/certificate?

Previous Post High School Education:

School _____

Address _____

Years attended _____ to _____ Cum GPA _____

School _____

Address _____

Years attended _____ to _____ Cum GPA _____

School _____

Address _____

Years attended _____ to _____ Cum GPA _____

Other relevant information: _____

EMPLOYMENT HISTORY

Current Employment:

Name of Company _____
Address _____
Position and responsibilities _____
Date began employment _____
Average number of hours worked/week _____

Past Employment:

Name of Company _____
Address _____
Position held _____ From _____ to _____
Reason for leaving _____

Other relevant information _____

COMMUNITY VOLUNTEERISM (Describe ways that you volunteer)

HONORS AND AWARDS RECEIVED

FINANCIAL NEED

Give the attached FINANCIAL NEED FORM to the financial officer at your school to complete for you.
Submit the completed form with your scholarship application.

ESSAY

Enclose your essay with your scholarship application.

INTEVIEW

Interviews will be conducted only with the three finalists.

Signature _____ **Date** _____

AUXILIARY OF MEMORIAL MEDICAL CENTER
SCHOLARSHIP FINANCIAL NEED FORM

To the applicant: Please give this form to your program's financial aid officer to complete and **return to you to be included in your scholarship application packet.**

To the financial aid officer: _____ is submitting an application for the Conemaugh Auxiliary Scholarship and needs you to complete this form. Thank you for your help in defining this applicant's financial status/ need.

1. Total cost of attendance for current academic year; _____

Estimate: year tuition/ fees _____
books _____
transportation _____
room _____
miscellaneous _____

2. Number of dependents the student has in his/her household: _____

3. Has the student completed a FAFSA form? Yes No

4. Total estimated family contribution on (EFC): _____

5. Total estimated self contribution from employment: _____

6. Is the student: dependent independent

7. Is the student a United States citizen? Yes No

8. Outstanding debt for previous education: _____

9. Outstanding debt for current education: _____

19. Estimate of financial need to support tuition, academic fees and additional expenses

very high high moderate low no need

Any additional information related to financial need for the Committee to consider for scholarship eligibility: _____

Name of program of study: _____

Name of educational facility: _____

Address of educational facility: _____

Financial aid officer

Name: _____

Phone number: _____ E-mail address: _____

Signature: _____ Date: _____