Southwest Healthcare Services Auxiliary

Healthcare Scholarship Application

Eligible applicants must have successfully completed all requirements for at least their freshman year of college. The applicant must have received written notification of acceptance into their healthcare related field of study. Southwest Healthcare Services' Auxiliary will accept applications from students originally from Bowman County, Slope County, and Harding County.

Full Name: ______________________ ______________________ ______________________
(LAST) (First) (MIDDLE)

Social Security Number: ______________________

Current Mailing Address: ______________________

Current Phone Number: ______________________ **Email Address:** ______________________

Name of Parents or Guardian: ______________________

Address of Parents or Guardian: ______________________

Name of Professional Degree Program or Field of Study:

____

Name and Address of College or University You Are Attending or Plan to Attend:

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Years Completed as of May: ______________ ______________________

Expected Date You Will Complete Your Degree Requirements (Month & Year): ______________

Are You Currently Enrolled as a Full-Time Student as Defined by Your College Or University? ________

Please Give Us The Anticipated Costs for One Semester:

Tuition: $ ______________

Misc. Fees: $ ______________

Books: $ ______________

Other: $ ______________ Consisting Of: ______________________

TOTAL COST PER ONE SEMESTER: $ ______________________

Have You Ever Worked or Volunteered at a Healthcare Organization? ______________________
(Yes/No)

If, yes, please let us know the name and location of healthcare organization:

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After you complete your education, would you consider employment at Southwest Healthcare Services in Bowman? Please answer yes or no and state reasons for your decision.

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<u>List two individuals who will provide us with a letter of recommendation for your application:</u>
(Excluding Relatives)

1.) Name: ____

Address: ____

Professional Relations to Applicant: ______________________

2.) Name: ____

Address: ____

Professional Relations to Applicant: ______________________

Include a copy of your most recent transcript and your written letter of acceptance into your healthcare program. If possible, please enclose a recent wallet size photo. In the event that you are awarded a scholarship, the photo will be used with an announcement story.

I hereby certify that the answers given are true and correct. I authorize investigation of all statements contained in the application and agree or reference checks as may be deemed to verify any and all information.

Signature: ______________________________ **Date:** ____________________

Applications must be postmarked by July 20th, ____________ and sent to:

Deb Sarsland
P.O. Box 258
Bowman, ND 58623

Margie Hande
P.O. Box 345
Bowman, ND 58623

Your application will not be complete until all components are accrued into our office. Please ensure your application form includes your current transcript, letter of acceptance into your healthcare program, and two letters of recommendation.