



**MON HEALTH MEDICAL CENTER FOUNDATION  
HEALTH CAREER SCHOLARSHIP APPLICATION**

**Deadline: MARCH 1, 2022**

**Amount:** \$1,000 per school term (\$500 per semester) for a maximum of 4 years (\$4,000)

**Approved Use:** Tuition, room and board, books, and lab fees

**Notification of Acceptance/Denial:** On or before May 1st

**ELIGIBILITY REQUIREMENTS:**

1. You must be a resident of one of one of the following counties at the time of application:

WV: Braxton, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, Randolph, Taylor, Tucker, Upshur and Wetzel

PA: Fayette and Greene

2. Be enrolled in, accepted to, or applied to a health career program at any accredited higher education school in the United States (college/university/technical school/trade school/etc.)

***\*If you are enrolled in the Mon Health Scholars program at Fairmont State University, you are not eligible to apply.***

Examples of acceptable programs:

- All Nursing certificates, degrees, or diplomas
- Nurse Practitioner; Physician's Assistant; Med Assistant; Med Tech; EMT
- Radiology; Ultrasound
- Pharmacy; Pharmacy Tech
- Lab Tech
- Physical Therapy
- Biomedical Engineering; Pre-Med

3. Scholastic minimums:

- 3.0 grade point average

OR

- test score of 21 or better on the ACT

OR

- test score of 1060 or better on the SAT

4. Be in need of financial assistance to meet educational expenses.

## **REQUIRED ATTACHMENTS:**

*Omission of any of the following will eliminate your application from consideration. Because we receive a large number of applications, we cannot match items sent in separately. We cannot use online databases to look up transcripts. You are responsible for obtaining, packaging, and delivering all required items together or risk being disqualified from consideration.*

1. An official copy or signed copy of high school transcript and/or higher education transcript(s) if applicable.  
  
*\*This requirement may be waived for non-traditional students (those who are not currently in school, or have not attended any school in the past 3 years or more). Please contact us to verify.*
2. A letter (1 page maximum) describing your reasons for selecting a specific health career, career goals, how you hope to use your degree in the future, the need for financial assistance and any other information you would like considered as a part of the application. *This will weigh heavily in your selection as a recipient.*
3. Two (2) written recommendations from your instructors, employers, community leaders and/or clergy who are unrelated and able to comment on your abilities, character, personality and commitment to education and health care. See page 4 of the application.
4. A copy of your latest submittal of the *Free Application for Federal Student Aid* (FAFSA) which can be obtained online at <https://studentaid.gov/>. Be sure to include the *entire form* (generally 7-8 pages).

Failure to Complete School Term: Our scholarship agreement will include a clause stating that if the scholarship recipient fails to complete a semester or prescribed term, any refund which is due will be made payable to the Mon Health Medical Center Foundation.

## **SUBMISSION:**

1. **Package application and attachments together in one, large flat envelope.**
2. **Please do not staple items together or submit 2-sided copies.**
3. **Must be received by March 1, 2022.**

### **Mail or Hand Deliver to:**

Joanna Wiley, Scholarship Coordinator  
Mon Health Medical Center Foundation  
1200 J. D. Anderson Drive  
Morgantown, WV 26505

304-598-1243

[WileyJ@MonHealthSys.org](mailto:WileyJ@MonHealthSys.org)

**2022 Application**  
**Mon Health Medical Center Health Career Scholarship**

Revised Nov 2021

Please print or type all information clearly!

DATE: \_\_\_\_\_

**Please choose one:**

[ ] I am graduating from high school in Spring 2022 and will attend higher education school in Fall 2022.

[ ] I am currently attending higher education school and will be attending in Fall 2022.

[ ] I am a non-traditional student planning to attend school in Fall 2022. (Not currently attending any school or have not been in school for past 3 years or more.)

**PERSONAL DATA:**

NAME: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

Address

City

State

Zip

CELL PHONE (preferred) or HOME PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

**EDUCATION:**

HIGH SCHOOL: \_\_\_\_\_

Year Graduated

Name of School

City/State

Guidance Counsellor (high school seniors only): \_\_\_\_\_

OTHER SCHOOLING: \_\_\_\_\_

COMPOSITE ACT and/or SAT: \_\_\_\_\_ GPA \_\_\_\_\_

**PLANNED ENROLLMENT:**

NAME OF CURRENT OR EXPECTED HIGHER EDUCATION SCHOOL:

\_\_\_\_\_

CURRENT or EXPECTED STATUS:       Full Time     Part Time (Min. of 6 hrs per semester)

CURRENT or EXPECTED PROGRAM OF STUDY: \_\_\_\_\_

EXPECTED GRADUATION DATE: \_\_\_\_\_  
(From Higher Education School)

**EMPLOYMENT DATA:**

HEALTH CAREER EMPLOYMENT AND/OR VOLUNTEER EXPERIENCE: \_\_\_\_\_

\_\_\_\_\_

CURRENT OCCUPATION: \_\_\_\_\_

DO YOU WORK OR VOLUNTEER FOR MON HEALTH?

YES \_\_\_ NO \_\_\_ If yes, list department(s) and dates: \_\_\_\_\_

\_\_\_\_\_

DOES EITHER PARENT WORK OR VOLUNTEER FOR MON HEALTH?

YES \_\_\_ NO \_\_\_ (If yes, list name and department): \_\_\_\_\_

**FAMILY & FINANCIAL STATUS:**

Choose one and complete applicable information:

SINGLE, DEPENDENT (listed as dependent by parents)

Parents' combined annual income: \_\_\_\_\_

Number of dependents including applicant: \_\_\_\_\_

Ages of dependents including applicant: \_\_\_\_\_

SINGLE, INDEPENDENT    Your current annual income: \_\_\_\_\_

MARRIED                      Combined household income: \_\_\_\_\_

Total income of you and your spouse

Number/Ages of dependents: \_\_\_\_\_

I AM ELIGIBLE TO APPLY FOR THE PROMISE SCHOLARSHIP     YES     NO

I HAVE APPLIED FOR THE PROMISE SCHOLARSHIP     YES     NO

List all other scholarships, grants, educational or personal loans, tuition waivers or other financial assistance requested (you may provide as an attachment). You may not accept more aid from all sources than exceeds your annual tuition, room and board, books and lab fees. Please specify type and amounts:

<u>NAME</u>	<u>STATUS</u>		
	Approved	Pending	Rejected
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

**CONSENT TO RELEASE INFORMATION**

I (we) hereby consent to the release of information from any of the above to the Mon Health Medical Center Foundation.

I hereby certify that the information set forth in this application is true and complete to the best of my knowledge. Further, I hereby give my permission for The Mon Health Medical Center Foundation or its designated representatives to contact my Financial Aid Officer, Guidance Counselor, or other Advisor at my school in which I am enrolled, have been previously enrolled or to which I have made application. This contract shall be for the purpose of soliciting and obtaining information which may be necessary or helpful to The Foundation in understanding my academic career and financial needs in connection with the processing of this application or for the purpose of auditing the use of scholarship funds received as a result of application made to The Mon Health Medical Center Foundation Scholarship Program.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or legal guardian of applicant if listed as dependent on 2021 Federal Tax Return

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Student

**Mon Health Medical Center Foundation**  
Letter of Recommendation - Health Career Scholarship

Complete Items 1 and 2 below before forwarding the form to the respondent.

1. APPLICANT: \_\_\_\_\_  
                                    First                                    Middle                                    Last

The Foundation requires two letters of recommendation from individuals who may provide pertinent information regarding your candidacy as a recipient of an award. Deliver this form to individuals who know you well enough to provide information requested. Include your signature on the line below if you wish to waive your rights under the Family Education Rights and Privacy Act of 1974.

2. WAIVER BY APPLICANT

I have asked \_\_\_\_\_ and \_\_\_\_\_ to provide letters of recommendation. I understand my rights under the Family Educational Rights and Privacy Act of 1974 to examine letters received by you on my behalf. In order to encourage the author to write with candor, I waive the right of access under the aforesaid statute to any confidential statement the writer may submit. I understand the execution of the waiver is not a condition for the consideration of my application.

\_\_\_\_\_ Date: \_\_\_\_\_  
Applicant's Signature

\*\*\*\*\*

Dear Respondent:

The above-named person is applying for a scholarship through The Mon Health Medical Center Foundation Scholarship Program. As a part of that procedure, the applicant is required to have two letters of recommendation returned to The Foundation as part of a total application package. You may put your response in a sealed envelope with the applicant's name on it. ***It must be returned to the applicant to be submitted with his/her application, which is due in the office of The Foundation by March 1, 2022.***

Your information will assist The Foundation in making important decisions. Please give us the benefit of your observations of the applicant based upon personal knowledge. Unless the rights afforded by the Family Educational Rights and Privacy Act of 1974 are waived by the applicant by the execution of the waiver above, The Foundation cannot assure the confidentiality of your comments.