MON HEALTH MEDICAL CENTER FOUNDATION
HEALTH CAREER SCHOLARSHIP APPLICATION

Amount: $1,000
Deadline: February 15, 2019
Approved Use: Tuition, room and board, books and lab fees
Notification of Acceptance/Denial: On or before April 20th

ELIGIBILITY REQUIREMENTS

1. Be a resident of one of these states and counties at the time of application award:

States	Counties
West Virginia:	Monongalia, Marion, Taylor, Preston, Wetzel, Harrison and Tucker
Pennsylvania:	Fayette and Greene

Exceptions: Full and part-time employees of Mon Health and their children will be eligible regardless of residence.

2. Be enrolled or planning to enroll in one of the following eligible career fields at any accredited school (no geographic restrictions):

One or Two-Year Degrees or Certificates:	Three, Four, or More Year Degrees:
Associate in Nursing	Pharmacy
Emergency Medical Technician/Paramedic	Nursing - MSN
Registered Radiology Technologist	Nursing - BSN
Pharmacy Technician	Nursing - Diploma
Health Information Technology	Nurse Practitioner
Medical Laboratory Technician	Dietician
Radiologic Technologist	Medical Technologist
Medial Assistant	Physician Assistant (Resulting Board Certification)
Ultrasound Technologist	Ultrasound Technologist
RNFA (Registered Nurse First Assistant)	Family Practice/Primary Care Physician
Surgical and Central Supply Technology	(must be in residency program)
Sterile Processing Technician	Biomedical Engineering

3. Meet the following scholastic minimums:
   A. For one and two year programs a 2.5 high school grade-point average and
      A test score of 21 or better on the ACT or
      A test score of 1250 or better on the SAT or
      A 2.5 grade-point average for applying college students
   B. For three and four year programs a 3.0 high school grade point average and
      a test score of 21 or better on the ACT or
      a test score of 1250 or better on the SAT.

NOTE: The above requirements are waived for non-traditional students.

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

The following items: MUST ACCOMPANY THE APPLICATION*
Must be mailed together in one, large flat envelope
Must be in the Foundation office no later than February 15, 2019

We do not match items sent in separately. We do not use online databases to look up transcripts. YOU are responsible for obtaining, packaging and delivering all required items together at one time or you will be disqualified from consideration.

REQUIRED ATTACHMENTS

1. An official copy or signed copy of high school transcript and/or college transcript(s) if applicable.

2. A letter 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. The letter must not exceed 200 words.

3. Two (2) written recommendations from your instructors, employers, community leaders and/or clergy who are unrelated and in a position to comment on your abilities, character, personality and commitment to education and health care. Letters must be included as part of your application. See page 4 of the application.

4. A copy of your latest submittal or print-out of the Free Application for Federal Student Aid (or FAFSA), which can be obtained on-line.

5. A stamped, self-addressed, business size (#10) envelope.

NOTE: Omission of any of the above information will eliminate your application from consideration.

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.

APPLICATION WITH ATTACHMENTS MUST BE RECEIVED
NO LATER THAN FEBRUARY 15, 2019
Mail/Bring to:

Executive Director
Mon Health Medical Center Foundation
1200 J. D. Anderson Drive
Morgantown, WV 26505

304-598-1208
WileyJ@MonHealthSys.org

2019 Application Revised 11-27-18

Mon Health Medical Center Health Career Scholarship

(Please print or type all information clearly; attach extra sheets if needed)

PERSONAL DATA: DATE: _____

NAME: _____

MAILING ADDRESS: _____
Address City State Zip

CELL PHONE (preferred) or HOME PHONE: _____

EMAIL: _____

EDUCATION: (Scholastic requirements waived for nontraditional applicants)

HIGH SCHOOL: _____
Year Graduated Name of School City & State

ACT COMPOSITE SCORE: _____ SAT SCORE: _____

G.P.A.: _____ RANK IN CLASS: _____

FOR HIGH SCHOOL SENIORS - NAME AND PHONE NUMBER OF GUIDANCE COUNSELOR:

_____

NAME OF COLLEGE/UNIVERSITY/TECHNICAL SCHOOL:

_____ Accepted ____ Pending ____
(currently attending or planning on attending in the fall)

CURRENT or PLANNED STATUS: Full Time _____ Part Time _____

CURRENT or EXPECTED PROGRAM OF STUDY: _____

EXPECTED GRADUATION DATE: _____

OTHER SCHOOLING: _____

I AM ELIGIBLE TO APPLY FOR THE PROMISE SCHOLARSHIP _____YES _____NO
I HAVE APPLIED FOR THE PROMISE SCHOLARSHIP _____YES _____NO

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:

CHECK APPROPRIATE LINE AND COMPLETE APPLICABLE INFORMATIION:

_____ 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: _____

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:

NAME	STATUS		
	Approved	Pending	Rejected
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

AGREEMENT TO VOLUNTEER

In applying for this scholarship, I agree to volunteer 5 hours of community service for Mon Health or the Foundation as a condition of acceptance for this scholarship. _____

Signature

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 2018 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
Name: (Print Clearly) _____
Last First Middle

SS#: _____

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

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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 February 15, 2019.***

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.