The Greg Smajda Memorial Healthcare Scholarship Fund
Amount: $500
Deadline: February 15, 2019
Approved Use: Tuition, room and board, books and lab fees
Notification of Acceptance/Denial: On or before April 20th

To be eligible for a scholarship, the applicant must:

1. **Be a non-traditional student (started college 3 or more years after graduating from high school).**
2. **Be an employee of Mon Health or an employee or associate of an organization performing healthcare services for the Mon Health.**
3. Enrolled in (or planning to be enrolled in) an accredited program of advanced healthcare education (beyond the high school graduate level). This program excludes graduate college education.
4. Applicant may be enrolled on a part-time or full time basis (undergraduate only).
5. Be in need of financial assistance to meet educational expenses.

Application Process

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

1. Submit this application along with a letter stating your reasons for selecting a specific health career, career goals, need for financial assistance and any other information you would like considered. The letter must not exceed 200 words.

2. Two (2) letters of recommendation (from non-relatives) are required to be included as part of the application.

3. You must attach 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.

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

*We will not match items sent in separately. We will 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.

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.

2019 Application Revised 11-27-18
Greg Smajda Memorial 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: _____

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: _____

EMPLOYMENT DATA:

HEALTH CAREER EMPLOYMENT AND/OR VOLUNTEER EXPERIENCE: _____

_____

WHAT IS YOUR CURRENT POSITION/OCCUPATION AT MON HEALTH? _____

_____

FAMILY & FINANCIAL STATUS:

CHECK APPROPRIATE LINES AND FILL IN INFORMATION ON APPLICABLE LINE:
_____ Single, dependent _____ Single, independent _____ Married

Your current annual income: _____ If married, spouse's current annual income: _____

If single, dependent, parents' current annual income: _____

Total number of dependents on income, including applicant: _____

Ages of dependents in family, including applicant: _____

List all other scholarships, grants, educational or personal loans, tuition waivers or other financial assistance requested (you may provide as an attachment). Please specify type and amounts:

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

I agree not to accept more aid from all sources than exceeds my annual tuition, room and board, books, lab fees.

How did you learn about this scholarship opportunity? _____

AGREEMENT TO VOLUNTEER: In applying for this scholarship, I agree to volunteer 5 hours of community service for Mon General Hospital or the Foundation of Mon General 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