MON HEALTH MEDICAL CENTER FOUNDATION
HEALTH CAREER SCHOLARSHIP APPLICATION

Deadline: MARCH 1, 2021
Amount: $1,000 per school year for a maximum of 4 years
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: Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, Randolph, Taylor, Tucker, Upshur and Wetzel
   PA: Fayette and Greene

2. Be enrolled, or plan to be enrolled, in a health career program at any accredited school in the United States. For example:

   - 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

3. Scholastic minimums: *These requirements are waived for non-traditional students.

   - 3.0 high school grade point average

     OR

   - a test score of 21 or better on the ACT

     OR

   - a test score of 1060 or better on the SAT

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

REQUIRED ATTACHMENTS

- MUST ACCOMPANY THE APPLICATION *
- Must be mailed together in one, large flat envelope.
- Please do not staple items together.

***** ***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 will be disqualified from consideration.***

1. An official copy or signed copy of high school transcript and/or college transcript(s) if applicable. NOTE: This requirement is waived for non-traditional students.

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 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 (FAFSA) which can be obtained online at **https://studentaid.gov/** . Be sure to include the ***entire form*** (generally 7-8 pages).

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 MARCH 1, 2021

Mail or Hand Deliver:

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

304-598-1243
WileyJ@MonHealthSys.org

2020 Application Revised Nov. 2020

Mon Health Medical Center Health Career Scholarship

Please print or type all information clearly!

DATE: _____

Please choose one:

[ ] I am graduating from high school in Spring 2021 and will attend college/technical school in Fall 2021.

[ ] I am currently attending college/technical school.

[ ] I am a non-traditional student not currently attending high school/college/technical school, but plan to attend school in Fall 2021.

PERSONAL DATA:

NAME: _____

MAILING ADDRESS: _____
Address

_____
City State Zip

CELL PHONE (preferred) or HOME PHONE: _____

EMAIL: _____

EDUCATION: Non-traditional students may skip to "Planned Enrollment".

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 mailing address of Guidance Counsellor:

_____

I AM ELIGIBLE TO APPLY FOR THE PROMISE SCHOLARSHIP [ ] YES [ ] NO

I HAVE APPLIED FOR THE PROMISE SCHOLARSHIP [ ] YES [ ] NO

PLANNED ENROLLMENT:

CURRENT OR PLANNED NAME OF COLLEGE/UNIVERSITY/TECHNICAL SCHOOL:

_____

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

CURRENT or EXPECTED PROGRAM OF STUDY: _____

EXPECTED GRADUATION DATE: _____
(From College/Technical School)

OTHER SCHOOLING: _____

_____

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: _____

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. _____	_____	_____	_____

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 2020 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

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, 2021.***

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.