APPLICATION FOR MEDICAL EXCELLENCE SCHOLARSHIP

Citizens Memorial Hospital • Citizens Memorial Healthcare Foundation

1500 North Oakland Ave • Bolivar, Missouri 65613 • phone 417.328.6426 • fax 417.328.6548
www.citizensmemorial.com

APPLICANT PLEASE READ: Thank you for your interest in a scholarship from the Medical Excellence Fund. Your application will receive consideration without regard to race, sex, national origin, age, physical or mental impairment or veteran status.

PLEASE NOTE: Any application that is turned in incomplete will not be accepted. For your convenience, there is a check list on page three of this application. Please follow all directions while completing this application and answer all questions as carefully, completely and honestly as possible.

Name

Address

City State Zip Code

County Phone

Social Security Number Email

Have you ever been employed by Citizens Memorial Hospital, Citizens Memorial Healthcare Foundation or Riverside Management and Rehabilitation? ☐ Yes ☐ No

If yes, where? Dates of Employment: From: To:

Do you have any relative(s) working for this organization? ☐ Yes ☐ No

If yes, please list their name(s), department, facility, and relationship:

Do you now have, or have you ever had, an illness, injury or chronic condition that would now prevent you from working in a health care facility? ☐ Yes ☐ No

If yes, please describe (include the name and address of your attending physician).

Have you ever had (in Missouri or any other state) a conviction or plea of guilty to a misdemeanor or felony charge which would include any suspended imposition of sentence, and suspend execution of sentence or any period of probation or parole?

☐ Yes ☐ No

If yes, please list the conviction(s), showing the offense and date. (The listing of conviction(s) will not necessarily disqualify you from consideration for scholarship application.)

Are you currently or have you ever been listed on a Missouri or other state's disqualification list? ☐ Yes ☐ No

If yes, please explain:

EMPLOYMENT HISTORY

Please list your most current position first and work back.

COMPANY NAME /ADDRESS	**DATES OF EMPLOYMENT**	**POSTIONS HELD /DUTIES OF YOUR JOB**	**REASON FOR LEAVINGMUST BE COMPLETED)**
	FROM:		
	TO:		
May we contact for a reference? Yes / No	NAME APPEARING ON FORMER EMPLOYER'S RECORDS		
Telephone Number	SUPERVISOR'S NAME		

COMPANY NAME /ADDRESS	**DATES OF EMPLOYMENT**	**POSTIONS HELD /DUTIES OF YOUR JOB**	**REASON FOR LEAVINGMUST BE COMPLETED)**
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COMPANY NAME /ADDRESS	**DATES OF EMPLOYMENT**	**POSTIONS HELD /DUTIES OF YOUR JOB**	**REASON FOR LEAVINGMUST BE COMPLETED)**
	FROM:		
	TO:		
May we contact for a reference? Yes / No	NAME APPEARING ON FORMER EMPLOYER'S RECORDS		
Telephone Number	SUPERVISOR'S NAME		

EDUCATION

IMPORTANT: Please submit an original official transcript for each secondary and post-secondary academic institution attended. Note: If you have a GED, include the original transcript with signature. Transcripts must be received with the application, before the February 27th deadline.

Check the highest grade completed. ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College ☐ 1 ☐ 2 ☐ 3 ☐ 4

High School Attended and Location				Graduation Date
College/University Attended	Dates Attended	Hours	Graduation Date	Degree Earned
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If additional space is needed, please attach a separate sheet

ENROLLMENT

This section is to be completed and signed by a representative of the health profession program of acceptance.

Name of Institution	Address	Tuition – Semester/Year	Academic Fees – Semester/Year
		$ Term	$ Term
Name of Contact Person		Title of Contact Person	Telephone
Academic Year Applied For	Student's Current Year in the Program	Program Start Date	Projected Graduation Date

I certify that the applicant is enrolled and in good standing or has been accepted for enrollment. Additional information deemed necessary will be provided by Citizens Memorial Healthcare upon request.

Signature of School Representative		School or Notary Stamp
Title	Date	

EDUCATIONAL OBJECTIVE

What certification or licensure will you be eligible for upon completion of this program?

How much assistance (annually) do you request?

How did you become interested in our Medical Excellence Scholarship?

Why do you seek a scholarship from the Medical Excellence Scholarship Fund?

In what health care setting do you wish to provide care upon completion of your chosen program? (Hospital, community, ambulatory care, long-term care, etc.)

Please state any other information that you believe would be helpful to the Scholarship Selection Committee (include extracurricular activities, hobbies, awards, honors, volunteer activities, etc).

PERSONAL STATEMENT

Please include, in your application, a personal statement describing your commitment to provide healthcare in Missouri. This statement should not exceed one single-spaced typewritten page. The personal statement should reflect your personal reason(s) for choosing health care as a profession, including your professional goals. Enclose the original personal statement and one copy with the completed application.

REFERENCES

You will also need to have three references completed to turn in with your application. The back page is an example of what we would like for them to fill out. Please make copies of this back page and give to the references of your choice. They will need to submit the form to you in a sealed envelope, with the envelope flap signed by the reference. You will need to submit these references with your application to be considered for this scholarship.

APPLICATION CHECKLIST

COMPLETE	COMPONENTS
NOTE: All documents submitted must be original. Faxed or e-mailed documents will not be accepted.	
	All sections of the application completed
	• enrollment section completed and signed by a school representative
	• application signed and dated
	Personal statement enclosed reflecting personal reason(s) for choosing health care as a profession
	Three reference forms enclosed in sealed envelopes, with the envelope flap signed by the reference
	Original high school transcript or GED enclosed
	Original post-secondary transcript(s) enclosed

It is the applicant's responsibility to ensure all components of the Medical Excellence Scholarship Application are complete. This checklist is provided to assist the applicant. Failure to submit a complete application may result in the application being deemed ineligible or in a reduction of points when scored.

By signing in the boxes below, you are stating that: I certify that I have read the foregoing application, which I understand the questions, which the answers given are true and authorized investigation of all statements contained in this application. I understand that a materially false answer will disqualify me from consideration for a scholarship from the Medical Excellence Fund. I release Citizens Memorial Healthcare, its agents and employees from any liability resulting from such investigation, and I authorize investigation of all statements contained in this application. I also understand that I will be obligated to work within the Citizens Memorial Healthcare organization upon graduation.

Printed Name of Applicant	Applicant Signature
Date	

Name of Applicant _____

SUMMARY SHEET TO BE COMPLETED BY THE REFERENCE

Please complete this form as accurate and honestly as possible. After you have completed this form, place the completed recommendation in an envelope, seal and sign your name across the seal of the envelope. Return this envelope to the applicant. The applicant will return the sealed envelope with his or her application by the February 28th deadline.

How well do you know this applicant? ☐ Very Well ☐ Fairly Well ☐ Minimally ☐ Unknown

How long have you known the applicant?

Identify the association you have had with the applicant. Check all that

☐ Instructor ☐ Employer/Supervisor ☐ Community Organization ☐ Academic Advisor ☐ Other

Please rate the applicant's achievement and potential by entering an "X" in the appropriate spaces below.

Skill	Exceptional	Above Average	Average	Below Average	Not Able to Respond
Decision Making Ability					
Organizational skills					
Communication skills: Written/Oral					
Adaptability to stress					
Positive attitude					
Integrity					
Interpersonal sensitivity					
Leadership ability					

In addition to the ratings, please give your evaluation of the applicant. It is important that you complete this section. You may want to indicate your perceptions of the applicant's strengths and limitations.

My recommendation is: ☐ Highly recommend ☐ Recommend ☐ Do not recommend

Signature of Person Making Recommendation	Date
Printed Name	Business and Position (if applicable)
Address	
Work Telephone Number	Home Telephone Number