SCHNECK MEDICAL CENTER

RN SCHOLARSHIP APPLICATION

Dear Scholarship Applicant:

Attached is a Registered Nurse scholarship application to be completed for consideration by the Dr. "Bud" Scholarship Committee for school year 2020-2021.

Also, attached is a copy of the requirements/guidelines to assist you in completing this application.

The completed application packet is to include:

1. Application form
2. Official transcript (Note: For 2020, due to circumstances surrounding COVID-19, unofficial transcripts will be accepted.)
3. One page single space typed autobiographical letter summarizing your career objectives
4. Proof of acceptance to a registered nursing program.

Once you have completed the application and its related documents, please return all forms post marked no later than May 29, 2020 to:

Tammy Jones
Schneck Medical Center
411 West Tipton Street
Seymour, IN 47274

The results of your scholarship application will be issued by letter upon review of your application by the Dr. "Bud" Scholarship Committee. If you have any questions concerning the application process, please contact Tammy Jones at 812.524.4236 or tjones@schneckmed.org.

GUIDELINES:

1. Primary consideration will be given to Jackson, Jennings, Scott, and Washington County residents. Residents of other counties may be considered based on available funds and at the discretion of the Scholarship Committee.

2. Candidate must have successfully completed freshman year of professional nursing program at a school of nursing accredited by an organization deemed acceptable by Schneck Medical Center.

3. Candidate must complete an application. Applications are available on March 2, 2020, at www.schneckmed.org.

4. Answer all applicable questions on the enclosed application. Please refrain from "see attached".

5. This is only an application and does not guarantee a scholarship.

DR. "BUD" GRAESSLE
SCHOLARSHIP APPLICATION

For candidates interested in pursuing a course of study to become a Registered Nurse.

Date: _____

I. PERSONAL INFORMATION:

Name:

_____

(Last) (First) (Middle) (Phone) (Email Address)

Home Address: _____

(Street) (City) (State/Zip)

Age: ____ SS# _____-____-_____ Resident of _____ County

Father's name: _____ Occupation: _____

Mother's name: _____ Occupation: _____

Number and ages of siblings (indicate if in college): _____

_____

Marital status: _____ If married, spouse's name:___ _____

Occupation of spouse: _____

Number of children: _____ Ages _____

II. EDUCATIONAL BACKGROUND

List School(s) Attended	Location	Years Attended	Major/Course of Study
High School			
College/University			
Other			

Anticipated date of college graduation: _____

What degree are you working toward? _____

Have you ever worked at Schneck? ( ) No ( ) Yes If yes, when: _____

Department worked: _____ Supervisor: _____

List job responsibilities: _____

III. EXTRACURRICULAR ACTIVITIES

Please list any organizations, clubs, and athletics you have been involved with (including years of involvement and leadership positions held: _____

_____

_____

_____

Honors and awards received: _____

_____

_____

_____

IV. EMPLOYMENT HISTORY (PAST AND PRESENT)

Job Title/Description	Period of Employment	Hours Worked/Wk

V. FINANCIAL RESOURCES

Estimated annual cost of attending school: $_____

Estimated parent contribution: $_____

Estimated student contribution: $_____

List 2020-2021 scholarships, grants, and funds:

_____ $_____

_____ $_____

_____ $_____

Existing educational loan balances: $_____

Other financial aid:

_____ $_____

Other financial considerations: _____

_____

_____

I certify that the information on this application is true and accurate to the best of my knowledge. I understand that information contained in this application and its supporting documents becomes property of Schneck Medical Center.

_____ _____

(Applicant Signature) (Date)