Golden Valley Memorial Hospital Auxiliary

Professional Health Care Scholarship Program Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

County of Residence: _____

Phone: _____ Email _____

Name of Parents,
Guardian or Spouse _____

Address: _____
Address

Education

High School: _____ Address: _____

Year Graduated: _____ GPA upon Graduation: _____

College or Program to which you have been accepted _____

Address: _____
Address

Program of Focus: _____

Budget Expectations

Are you or your parents financially able to pay your full expenses for professional health care training: Yes No

References

Please list three Character references. Do NOT list relatives

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Volunteer and Employment Work Experience

Place _____ Length of Employment or Volunteer Work _____

Personal Statement

In one paragraph, please describe why you are interested in entering the healthcare field and why you believe you are deserving of this award.

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to award, I understand that false or misleading information in my application or interview may result in my loss of award.

Signature: _____ Date: _____