Applicant Name_____

Last First

School (currently attending)_____

ST. MARY MEDICAL CENTER AUXILIARY
2025 COLLEGE STUDENT
SCHOLARSHIP APPLICATION

Application Deadline is Friday, April 25th, 2025, by 2:00 PM.

To submit your application:

- Return to the Gift Shop volunteer
- Via email to mrdixon@powershealth.org with the subject line "Scholarship Application 2025-2026 School Year."

Carefully review the **St. Mary Medical Center Auxiliary 2025-2026 Scholarship Program Guidelines** before completing this application. Neatness is essential. An incomplete packet will be disqualified upon receipt. Be certain to sign and date the last page of the application. This application is three (3) pages.

Application Checklist:

_____If the applicant is an employee, employee dependent, volunteer, or direct descendent of an active adult volunteer in good standing, a photocopy of the employee's or volunteer's badge is required. Employees must meet the criteria for employee dependency to qualify (St. Mary Medical Center Auxiliary 2025-2026 Scholarship Program Guidelines). Applicants may apply to only one system hospital for a scholarship.

_____Official transcript* from your school. Spring transcripts should be submitted prior to interviews if the applicant qualifies. **Transcript **__must be official__**.

_____Two letters of recommendation in support of your application; both should be professional recommendations. Professional Recommendations must be signed and placed on official letterhead.

_____A typed essay reflecting goals, accomplishments, and/or challenges encountered in the past year. Has the path to attain those goals changed since starting college? What involvement did you have within the community in the last year? Please include any information you think we should know that would assist us in the decision-making process.

_____A copy of the applicant's social security or permanent resident card (green card).

For questions, please call the office of Volunteer Services at 219-947-6011.

ST. MARY MEDICAL CENTER AUXILIARY SCHOLARSHIP

COLLEGE APPLICANT INFORMATION

Name: _____
Last First Middle

Permanent
Address: _____
Street City State Zip Code

Date of Birth:_____

Phone #: (home)_____ (cell)_____

Email: _____

Preferred means of communication: _____

COLLEGE/UNIVERSITY/TECHNICAL SCHOOL INFORMATION

School Currently Enrolled

_____

School Address

_____

Phone Number

_____

Other outside scholarship(s) you have received or expect to receive (if known at this time):

Name/Source of Scholarship:_____

Name/Source of Scholarship:_____

Name/Source of Scholarship:_____

Major Field of Study:_____

Please circle one:
Are you a United States Citizen? Yes or No
Are you a green card holder? Yes or No

Do you feel that your grades are an accurate indication of your ability to succeed in college?

_____ Yes _____ No

Briefly explain why the above answer was chosen:

_____

_____

_____

_____

PLEASE READ THE STATEMENT BELOW AND SIGN THE APPLICATION. THIS APPLICATION IS NOT COMPLETE WITHOUT THE SIGNATURE OF THE APPLICANT, PARENT OR GUARDIAN VERIFICATION.

I affirm that the information submitted as a part of, and in support of, this application is complete and correct. I agree to report any changes in this information to the St. Mary Medical Center Auxiliary Scholarship Committee. I understand that if any person knowingly makes a false statement or misrepresentation in this application or any information submitted in support of this application, any financial assistance awarded shall be subject to cancellation, and I will be liable for repayment of financial assistance received or paid for my benefit. I agree that if I am selected to receive financial assistance, I will sign the St. Mary Medical Center Auxiliary Scholarship Committee acceptance contract and provide a current photograph of myself for marketing purposes. Furthermore, I authorize Powers Health to utilize this information for public relations purposes**.**

_____ _____

Signature of Applicant **Today's Date**

PARENT OR GUARDIAN VERIFICATION

The undersigned, being a parent or guardian of the student making the foregoing application, hereby certifies to the St. Mary Medical Center Auxiliary Scholarship Committee that I have read the foregoing application and reviewed the documents and other information to be submitted with the application that the information contained in the application and in the supporting submissions is true and accurate in every respect and that the student applicant is my legal dependent. I agree to submit any additional documentation to prove or verify the application and/or submissions made therewith, if requested by the Trustee or the St. Mary Medical Center Auxiliary Scholarship Committee, including, but not limited to, proof and verification of the applicant's dependence on me for principal support and maintenance. I agree to allow the Volunteer Services Department of St. Mary Medical Center to verify my employment with Powers Health Human Resources. Furthermore, I authorize Powers Health to utilize this information for public relations purposes.

_____ _____

Signature of the Parent or Guardian **Today's Date**

_____

Printed Name