



DELTA COUNTY MEMORIAL HOSPITAL FOUNDATION SCHOLARSHIP APPLICATION FOR HEALTH CARE EDUCATION

Please type or print the following information:

NAME: _____

ADDRESS: _____

(City) (County) (State) (Zip)

PHONE: (Day) _____ (Evening) _____

DATE OF BIRTH _____ ETHNICITY _____

Please briefly note the institution you plan to attend, and the course you plan to take:

PRIOR EDUCATION

HIGH SCHOOL: _____ YEARS COMPLETED: _____

GRADUATION DATE: _____ GED REC. DATE: _____

COLLEGE: _____ MAJOR: _____

DEGREE: _____ DEGREE DATE: _____

SPECIALTY EDUCATION DEGREE: _____

INSTITUTION: _____ DEGREE DATE: _____

WORK HISTORY

CURRENT EMPLOYER (if applicable): _____

PREVIOUS EMPLOYER (if applicable): _____

REFERENCES

Please provide three letters of reference from individuals such as a teacher, school official, employer, advisor, community leader or other person who knows you and can provide information about your strengths, weaknesses, abilities and aspirations. **Please also provide the following information about them:**

Name	Address	Phone	Years Known

CAREER PLANS

Briefly state your educational and career goals:

SIGNIFICANT PERSONAL ACHIEVEMENTS

Explain any personal challenges overcome; awards or honors you have received:

COMMUNITY SERVICE

Please list any volunteer activities in which you participate; your contributions made to the community:

FINANCIAL INFORMATION

Student/Dependents Expenses		Student/Dependents Resources/Income	
Tuition and Fees	\$	Student Wages/Tips	\$
Books and Supplies	\$	Spouse's Wages/Tips	\$
Rent and Utilities	\$	Other Income	\$
Food & Household Supplies	\$	Financial Assistance	\$
Clothing, Laundry, etc.	\$	Parents' Contribution	\$
Transportation	\$	Grants (i.e., Pell, etc.) *	\$
Day Care	\$	Scholarships *	\$
Medical and Dental	\$	Loans *	\$
Other	\$	Other *	\$
Other	\$	Other *	\$
Total Expenses	\$	Total Resources	\$

NOTE: Please be sure to review expenses Carefully to make sure you have included All reasonable costs you will incur this year.

*Only include monies already approved

Please use this space for additional information you would like to provide:

Signature

Date

CHECKLIST OF ATTACHMENTS:

Important: Scholarship applications are reviewed quarterly in February, May, August and November of each year. Be sure all required items are included, or will be submitted no later than first of the month for your application to be considered during the quarterly scholarship application review.

- **Transcripts from High School, College or Specialty Education**
- **Letter of Acceptance and Tuition Bill**
- **Letters of Reference**

**PLEASE RETURN APPLICATION TO THE
DELTA COUNTY MEMORIAL HOSPITAL FOUNDATION,
1501 E. 3RD STREET, DELTA, CO. 81416 PHONE: 719-874-2291**



“Caring Through Education & Service”

DELTA COUNTY MEMORIAL HOSPITAL FOUNDATION

SCHOLARSHIP CRITERIA/CONDITIONS

- 1) The applicant must be a high school graduate and a U.S. Citizen.
- 2) The applicant must be planning to further his/her education in a health care related profession.
- 3) The applicant must show proof of having been accepted in an accredited health related program.
- 4) The applicant must show proof of financial need and academic capability.
- 5) Recipients of the Delta County Memorial Hospital Foundation scholarship funds will be awarded half of the scholarship for the first semester they are enrolled in an accredited institution.
- 6) They will be required to sustain a 2.5 grade point average, or better, and will be required to furnish a transcript from the first semester. If they fail to sustain at least a 2.5 grade point average, the remainder of the scholarship will be revoked.
- 7) If the applicant maintains a satisfactory record, he/she will be awarded the second half of the scholarship at the beginning of the second semester.
- 8) The funds will be paid directly to the school or institution in which applicant is enrolled.

All Scholarship Applications should be mailed or delivered to:

Delta County Memorial Hospital Foundation
P.O. Box 10100
DELTA, CO 81416-5003

PHONE: 874-2730