OSF Holy Family Medical Center
Auxiliary Scholarship Application

All blanks should be completed, using 'NA' where applicable.
Application must be received by June 1st to be considered for the fall.

Personal Information

Name:____
Last First MI

Address:____
Street City Zip

Home Phone:_______________________________ Cell Phone:_________________________________

Date of Birth:____________________ Email Address: ____

List number, age and relationship of any dependents: ____

____

List number and age of any siblings: ____

____

Educational Information

Name of school you will attend:____

Have you been accepted? _______ Date School Begins: ______________________________________

What is your course of study? ____

What are your professional goals? ____

List all schools attended beyond elementary school and degrees or diplomas granted:

____

____

What honors (academic/otherwise) have you received and when?

____

____

If you are not currently in school, how have you been occupied since leaving school?

____

____

Occupational Information

List all jobs you have held (dates/employer/type of work):

____

____

____

In what health related fields or activities have you been involved?

____

____

What qualifications do you feel you have for the occupation you have chosen?

____

____

Financial (Confidential) Information.

(If independent of parents financial assistance, indicate NA)

Father's Name: _________________________________ Occupation: ______________________

Place of Employment:____

Mother's Name: ________________________________ Occupation: ______________________

Place of Employment: ____

Spouse's Name: _________________________________ Occupation: ______________________

Place of Employment: ____

Who is the primary contributor to your support? ____

Do you intend to work during school? ____________ How many hours per week? _____________

Below, list your anticipated expenses for the coming school year:

Tuition and Fees: __________ Room/Board: ____________

Books & Supplies: _________ Transportation: ___________

Other (explain): ____

List other scholarships and grants to be received and amount:

____

____

Additional comments regarding financial needs or explanation of above information:

____

____

____

Address of the financial aid office of your school:

____

____

____

Student ID Number: ________________

As a part of your application, please submit the following:

1. An official high school and/or college transcript. May be mailed to OSF HealthCare Holy Family Medical Center, C/O: Stephanie Hilten, 1000 West Harlem Ave., Monmouth, IL 61462.
2. Submit a brief statement of why you deserve this scholarship.

Consent for release of information:

I hereby consent to the release of any information in connection with the application that may be of assistance to the Board of the Auxiliary in evaluating my scholarship application. I hereby waive any confidentiality with respect to such information insofar as the Holy Family Medical Center Auxiliary is concerned, since it is my understanding that the information will be used only in the evaluation of my application for the scholarship.

Signature of Applicant: ____ Date: ____________________