SSMHealth
St. Mary's Hospital Foundation

Student Scholarship

Application Deadline - 4:30 p.m. CDT, March 1st

APPLICANT INFORMATION			
Last Name:	First Name:		Middle Initial:
Maiden Name/Other Names Used:		SSN#:	
Address:		Telephone (home): ( )	
City:	State:	Zip:	County:
E-mail:		Telephone (cell): ( )	
How long have you lived at your address?			
Are you a dependent of a St. Mary's Employee? ❑ Yes ❑ No			
Are you eligible to work in Missouri two years following graduation? ❑ Yes ❑ No			
How did you learn about the St. Mary's Foundation Scholarship Program?			

PROGRAM TYPE

Indicate the program in which you are enrolled in or to which you have been accepted

❑ Audiologist	❑ Nursing (LPN)	❑ Respiratory Therapist (RRT)
❑ Clinical Social Worker	❑ Occupational Therapist (OT or OTR)	❑ Speech/Language Therapist
❑ Medical Records	❑ Pharmacist (Pharm.B or Pharm.D)	❑ Other Licensed and/or
❑ Nurse Anesthetist	❑ Physical Therapist (PT)	Registered Profession _____
❑ Nursing (R.N.)	❑ Registered Radiologic Technologist (RT)	_____

** PLEASE SUBMIT AN **ORIGINAL TRANSCRIPT** WITH THIS APPLICATION FOR EACH **
PRIOR ACADEMIC INSTITUTION ATTENDED. IF YOU HAVE A GED, INCLUDE
THE **ORIGINAL TRANSCRIPT** WITH SIGNATURE.

Circle the highest grade completed: **High School:** 9 10 11 12 **GED** **College:** 1 2 3 4

High School Attended and Location:			Graduation Date:
Technical/Vocational School Attended and Location:		Dates Attended:	Degree Earned:
College/University Attended and Location:	Dates Attended/Hours:	Graduation Date:	Degree Earned:

All information is confidential and for programmatic purposes only.

Revised: 1/21/16

College/University Attended and Location:	Dates Attended/Hours:	Graduation Date:	Degree Earned:

** **IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH SEPARATE SHEET.** **

ENROLLMENT VERIFICATION			
Name of School/College/Institution:	Address:		
Contact Person:	Title of Contact Person:		Telephone: ( )
Current Year in the Program:	Academic Year:	Program Start Date:	Cost per semester?

APPLICANT MUST SHOW EVIDENCE OF ACCEPTANCE TO AN ACADEMIC PROGRAM AND SHOW PROOF OF ENROLLMENT.

EMPLOYMENT		
Are you currently employed? ❑ Yes ❑ No	Start Date:	Do you plan to remain with this employer? ❑ Yes ❑ No
If yes, name and address of employer:		May we contact you at work? ❑ Yes ❑ No Work Phone: ( )

PERSONAL STATEMENT

On a separate sheet, submit a personal statement describing your commitment to provide health care in Missouri. This statement is not to exceed one single-spaced typewritten page. **Please also attach a listing of extracurricular**, **community, volunteer or health care activities you have been involved with.** *(It is important for the selection committee to have this information from all applicants.)*

APPLICATIONS MUST BE RECEIVED BY 4:30 P.M. CDT, March 1st.
INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED. QUESTIONS REGARDING THE APPLICATION AND SELECTION PROCESS SHOULD BE DIRECTED TO THE ST. MARY'S FOUNDATION DEVELOPMENT OFFICE AT 573-681-3742 or email at Anne_Rost@ssmhc.com.

I certify that the information contained in this application is true, complete and correct to the best of my knowledge, and that all funds will be used for educational-related expenses in the current academic year. I hereby authorize the release of personal, scholastic and financial information related to my educational status from any academic institution I have attended in the past, am currently enrolled or may be enrolled as a student in the future, to the St. Mary's Foundation Scholarship Committee.

Signature of Applicant:	Date:

NOTE: *This student scholarship program is a competitive process, and only eligible applications will be evaluated. All eligible applications may not receive funding. The scholarship application must be completed in its entirety to be eligible for consideration.*