MEMORIAL HEALTHCARE FOUNDATION
PEGGY GULICK NURSING SCHOLARSHIP
APPLICATION PACKET

ENCLOSED:

General Policy
Scholarship Application
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Confidential Recommendation Forms
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Memorial Healthcare Foundation
Peggy Gulick Nursing Scholarship
General Policy

Name of Scholarship Fund: The Peggy Gulick Nursing Scholarship.

Purpose:

The purpose of this scholarship award is to provide opportunities for education advancement in the field of nursing, and to enter the registered nursing profession.

Scholarship funds are awarded for use by the recipient to pay tuition and books expenses and are to be paid directly to the educational institution.

Eligibility Criteria:

- Applicants must already be accepted into a nursing program before they may be considered for the scholarship.
- Applicants must be individuals interested in pursuing an ADN or BSN (other nursing degrees are not eligible for consideration)
- Applicant must provide 2 letters of reference

Selection Criteria:

Criteria used for selection of scholarship recipients include:

- Applicant must be a high school graduate.
- Academic performance: must have an overall GPA of 3.0 on a 4.0 scale for initial award as well as for renewal
- Special skills and interests that demonstrate good work habits, commitment to a project, or others that translate to becoming good nurses and employees.
- Performance on Aspirations and Goals Essay: including content, clarity of communication and presentation.
- Applicants should have previous health care experience.

The selection process for this scholarship is without regard to race, religion, gender, national origin or financial need.

Award Amounts:

The scholarship award will be determined in part by funds available. An initial award is $2,500 and renewals will be for "up to" $2,500, both dependent on funds deemed available by the Memorial Healthcare Foundation.

Renewal Criteria:

This Scholarship is renewable for one (1) year. To be considered for renewal, a Renewal Application must be submitted by the scholarship recipient along with a copy of current transcripts. Renewal depends primarily on:

- Retention of an academic overall GPA of 3.0 on a 4.0 scale.
- Letter of recommendation from an employer and someone involved in their recent academic nursing experience.

If the scholarship is renewed, before receipt of scholarship monies, the recipient will be required to prove continued employment in good standing at Memorial Healthcare.

Application Procedures:

Applications for the Peggy Gulick Nursing Scholarship can be obtained from the Memorial Healthcare Foundation Office or online at www.memorialhealthcare.org.

Memorial Healthcare Foundation
PEGGY GULICK NURSING SCHOLARSHIP
APPLICATION

The following must be completed by the <u>Applicant.</u> Please type or print information.

Applicant's Name_____
(Last Name) (First) (Middle Initial)

Address_____

City_____ **State**_____ **Zip Code**_____

E-mail _____ **Telephone (_____)**_____

High School Attended_____

City_____ **State**_____

College Attending_____

City_____ **State**_____

Date Begun_____ **Full Time student? _____ Yes _____ No**

Type of Nursing Program enrolled in: ADN _____BSN_____
(other nursing degrees are not eligible for consideration)

Expected date of degree completion_____

Describe your work experience (if any) beginning with the most recent. Indicate dates of employment (attach additional sheet(s) if necessary).

Company	Position	Date From	Date To	Supervisor

List all collegiate activities (if any) in which you have participated. Include any special awards, honors and offices held (attach additional sheets if necessary).

List all community activities (if any) in which you have participated during the past 4 years. Include any special awards, honors and offices held (attach additional sheets if necessary).

List any special skills or interests that you have. Include any special awards or honors you've received (attach additional sheets if necessary).

The Peggy Gulick Nursing Scholarship requires that recipients be employed at Memorial Healthcare in good standing for a period of no less than one (1) year. Repayment of scholarship monies will be expected if the terms of the Employment are not fulfilled.

The undersigned hereby acknowledges that the information provided in this application, including any enclosed documents, is true and correct to the best of their knowledge.

Applicant Signature **Date**

Memorial Healthcare Foundation
PEGGY GULICK NURSING SCHOLARSHIP
GOALS AND ASPIRATION ESSAY

Please provide essay responses to the following questions. Address each question on a separate sheet of paper and limit each response to the length indicated. Head each page with your full name and a statement of the question being answered. Essays must be in a typed format. Essays will be judged upon thoroughness of response, clarity of thoughts and sincerity of purpose. Enclose your responses with your application materials.

A. Statement of Career Goals:
What personal and professional goals have you tentatively established for the next five years? What are your career aspirations? How will your nursing degree contribute to these goals and aspirations? (1 page in length)

B. Other Relevant Information:
What other information do you believe is important in an assessment of your application? (1 page in length)

Examples may include

- **any unusual family or personal circumstances that have affected your academic achievement**
- **work experience you have had**
- **your participation in school and community activities**
- **something of which you are especially proud**

Memorial Healthcare Foundation
PEGGY GULICK NURSING SCHOLARSHIP
CONFIDENTIAL RECOMMENDATION

Applicant's Name_____
(Last Name) (First) (Middle Initial)

To the Applicant: Please print your name above and sign the statement below. The Family Educational Rights and Privacy Act of 1974 and its amendments guarantee students access to education records concerning them. Students are permitted to waive their right of access to recommendations. A waiver of their right of access may permit recommenders to submit a more candid evaluation. The following signed statement indicates the wish of the applicant with respect to this recommender's recommendation.

☐ *I waive my right of access to the following recommendation.*
☐ *I do not waive my right of access to the following recommendation. I understand that under the law my waiver provides that I only have access to this recommendation.*

_____ _____
Signature ***Date***

To the Recommender: The person whose name appears above is applying for a scholarship with the purpose of encouraging scholarship recipients to pursue studies in select health care disciplines. The applicant has requested that your evaluation be included as part of the information upon which the selection decision will be based. We value your direct contact with the applicant and will appreciate your responses to the following questions as candidly and specifically as possible. Your responses will assist the Scholarship Committee in the evaluation of the applicant's qualifications for the receipt of a scholarship. We realize the amount of time and care necessary to complete a thoughtful recommendation and are grateful for your assistance.

Our application procedure requires that the applicant gather all documents including recommendations and submit a complete set of materials with the application. This system allows the applicant to know the completed application has been submitted and facilitates our control over materials. Please enclose the completed recommendation in an envelope. Please seal the envelope, sign across the seal, and return it to the applicant so that it can be submitted with the application.

Name of Recommender (print or type) _____

Position or Title _____

Organization _____

Address

_____

Telephone Number _____

Please rate the applicant in the following attributes, relative to others whom you have known in a similar capacity.

	Outstanding	Strong	Average	Fair	Poor	Not Observed
Integrity						
Motivation & Drive						
Leadership Potential						
Imagination & Creativity						
Self-Confidence						
Ability to Work w/Others						
Intellectual Ability						
Ability in Oral/Written Expression						

Please address the following items in a narrative form and include any other information that will help the Scholarship Committee make its decision:

- **How long and in what connection have you known the applicant?**
- **What do you know of the applicant's future academic plans?**
- **What special qualities does the applicant possess which would contribute to success in the study of a health care discipline?**
- **What qualities should the applicant improve upon for success in the study and a subsequent career in a health care discipline?**

Please check one:

_____ **I *strongly recommend* this applicant for receipt of a Memorial Healthcare Foundation Scholarship.**

_____ **I *recommend* this applicant for receipt of a Memorial Healthcare Foundation Scholarship.**

_____ **I *recommend with reservation* this applicant for receipt of a Memorial Healthcare Foundation Scholarship.**

_____ **I *do not recommend* this applicant for receipt of a Memorial Healthcare Foundation Scholarship.**

Signature _____ **Date** _____

Memorial Healthcare Foundation
PEGGY GUICK NURSING SCHOLARSHIP
TRANSCRIPT REQUEST

To the Applicant: Print the information requested below and send this form to your College or University registrar.

Name_____
(Last Name) (First) (Middle Initial)

Student Number _____

School_____

Dates of Enrollment_____ **Degree and Year**_____

I hereby request the release of an official transcript and comments on my academic record to the Memorial Healthcare Foundation Scholarship Committee.

_____ **Date**_____
Signature

To the Registrar: The person named above is applying for a Memorial Healthcare Foundation Scholarship Award and we are asking your assistance in our effort to provide transcript control in the application process. Please complete this form and enclose it with an official copy of the applicant's academic transcript in an envelope. Please seal the envelope, sign across the seal, and return it to the applicant so that it can be submitted with the application. If this procedure is contrary to your policy, please send the transcript directly to the Memorial Healthcare Foundation Office, Scholarship Committee, 826 W. King Street, Owosso, MI 48867. Thank you for your cooperation.

_____ **Date**_____
Signature and title of College or University official