



THE CHAMBERSBURG HOSPITAL MEDICAL STAFF &
THE WAYNESBORO HOSPITAL MEDICAL STAFF
2018-2019 SCHOLARSHIP APPLICATION

THIS SCHOLARSHIP PROGRAM APPLIES SPECIFICALLY TO THOSE STUDENTS WHO RESIDE IN FRANKLIN COUNTY AND/OR UTILIZE SUMMIT HEALTH AS THEIR PRIMARY SOURCE FOR HEALTHCARE AND ONLY THOSE STUDENTS WHO ARE GRADUATING FROM HIGH SCHOOL OR ARE ALREADY PURSUING AN UNDERGRADUATE PROGRAM IN A HEALTHCARE FIELD OF STUDY.

NOTE: Scholarship does not apply to those students who are already healthcare providers seeking an advanced degree in healthcare.

Instructions: Please answer all questions completely. For questions that do not apply to you, write N/A along with a brief explanation.

Date of Application: _____

SECTION A: PERSONAL INFORMATION

Applicant's Name: _____

Home Address: _____

City, State: _____ Zip Code: _____ Telephone: _____

(Preferred Method of Communication)

E-mail Address: _____

Date of Birth: _____

Place of Employment: _____

Employer's Address: _____

City, State: _____ Zip Code: _____ Telephone: _____

Hire Date: _____ Employment Status: _____ (full-time,
part-time, relief, leave of absence)

Father's Name & Address: _____

Father's Place of Employment: _____

Mother's Name & Address: _____

Mother's Place of Employment: _____

Name of High School Attended and Graduation Date: _____

SECTION B: ACADEMIC INSTITUTION INFORMATION

Name of Academic Institution in Which You Are Enrolled or Plan to Enroll:

Academic Advisor: _____ Telephone: _____

Projected Date of Graduation: _____

Program or Degree Anticipated: _____ Previous GPA: _____

Estimated Education Cost Per Semester:

Tuition & Fees: _____ Books & Supplies: _____

Room & Board: _____

Other Expenses (list each): _____

List Other Scholarships or Financial Aid for Which You Have Applied or Received:

Amount(s): _____

Where Did You Discover the Availability of This Scholarship? _____

Extracurricular Activities: _____

Leadership Positions Held in School and Community Organizations: _____

What Community Service Have You Performed? _____

SECTION C: FINANCIAL INFORMATION

Estimated Annual Income of **Applicant**:

_____ \$0 - \$999 _____ \$2,000 - \$2,999
_____ \$1,000 - \$1,999 _____ Above \$3,000

Estimated **Family** Annual Income:

_____ Below \$15,000 _____ \$25,000 - \$35,000
_____ \$15,000 - \$24,999 _____ Above \$35,000

Number of Children in Family Who Are Older Than You: _____

Number of Children in Family Who Are Younger Than You: _____

Number of Children Living at Home: _____

IMPORTANT INFORMATION:

Along with your completed application, the following documents **MUST** be attached to be considered for this scholarship:

- A descriptive essay not exceeding two (2) double-spaced pages about yourself to include the following:
 - Information regarding your background.
 - The reason why you feel that you should be considered for this scholarship.
 - What you feel your contribution would be to the Chambersburg and/or Waynesboro Hospital specifically or the healthcare field in general.
- Two (2) letters of recommendation must accompany this application. Those recommendations are to be from either professors or community leaders, or Summit Healthcare Providers.
- Transcripts of previous course work (either high school or college if already enrolled in a program).

SCHOLARSHIP GUIDELINES:

This scholarship will not exceed \$1,500. Financial need is a major consideration in the selection of the recipient of this scholarship. The final selection will be made by the Scholarship Committee made up of Medical Staff members of both the Chambersburg and Waynesboro Hospitals.

Funds will be paid directly to the academic institution.

Return to: Mrs. Julie A. Frey
 Scholarship Program Coordinator
 The Chambersburg Hospital
 Medical Affairs Office
 112 North Seventh Street
 Chambersburg, PA 17201

APPLICATIONS MUST BE POSTMARKED NO LATER THAN: APRIL 15, 2018