MITCHELL COUNTY HOSPITAL HEALTH SYSTEMS
SCHOLARSHIP APPLICATION

The Mitchell County Hospital Health Systems Scholarship Program is offered to individuals who desire to obtain and/or increase their education in a health related profession. The scholarship (an educational loan) is funded by Mitchell County Hospital Health Systems upon the recommendation of the respective department manager and Administrator. The funding of this scholarship is determined according to the needs of the hospital. **The applicant is bound by the terms of the Mitchell County Hospital Health Systems Scholarship Agreement if a scholarship (forgivable educational loan) is awarded as set forth in Mitchell County Hospital Health Systems Scholarship Agreement.**

Name: _____
Last First Middle

Address: _____
Street/P.O. Box City State Zip Code

Phone: (home) ( ) _____ (work) ( ) _____

Place of Birth: _____
City State

Please provide names, addresses and phone numbers of two (2) relative or friends at different addresses who will know how to contact you.

1 – Name: _____
Address: _____
Street/P.O. Box City State Zip Code

Phone: _____ Relationship: _____

2 – Name: _____
Address: _____
Street/P.O. Box City State Zip Code

Phone: _____ Relationship: _____

Please provide the names, addresses and phone numbers of three (3) individuals who can provide you with a professional and/or personnel reference. For professional references, list profession under Relationship below.

1 – Name: _____
Address: _____
Street/P.O. Box City State Zip Code

Phone: _____ Relationship: _____

2 – Name: _____
Address: _____
Street/P.O. Box City State Zip Code

Phone: _____ Relationship: _____

3 – Name: _____

Address: _____
Street/P.O. Box City State Zip Code

Phone: _____ Relationship: _____

COLLEGE OR SCHOOL YOU PLAN TO ATTEND:

Name: _____
Mailing Address: _____
Street/P.O. Box City State Zip Code

Name of Program You Plan to Enroll: _____

Have you applied? ( ) Yes ( ) No If Yes, have you been accepted? ( ) Yes ( ) No

Initial date of enrollment: _____ Anticipated date of graduation: _____

Will licensure and/or certification be required upon graduation? ( ) Yes ( ) No

If "Yes", what licensure and/or certification is required _____

Have applied for other scholarship? ( ) Yes ( ) No. If "yes", amount applied for $_____

Have you received any other scholarships? ( ) Yes ( ) No.

If "yes", amount received $_____.

I attest that the information contained in this application is correct and accurate to the best of knowledge. **I acknowledge I have read the Mitchell County Hospital Health Systems' Scholarship Agreement and agree to be bound by its terms.**

Printed Name: _____

Signature: _____ Date: _____