



Scholarship Application Instructions

The West Valley Hospital Foundation awards scholarships to students pursuing careers in healthcare professions. Special consideration is given to applicants who are West Valley Hospital employees.

Qualifications:

Applicants must have a permanent residence in **Polk County** (unless a current employee or family member of a current employee at West Valley Hospital.) Students must be enrolled in at least a part-time class schedule to qualify. **(6 cr. minimum)**

Selection:

The West Valley Hospital Foundation Scholarship Committee will make all final scholarship selections. The committee will consider overall presentation and completeness of the application packet, letter of reference, academic performance, field of study, volunteer/extracurricular activities and financial need. Notification of results will be sent by April 30, 2010.

On-line Application Instructions:

1. You can print out the packet first and fill in by printing clearly on the form, or you can type into each field and print the completed form. Please read and complete the application thoroughly. You must include the items listed below along with your application form. **Incomplete application packets will not be considered.** Please contact the Foundation office at 503-831-3456 if you have questions.
2. Completed application packets **must be received in the Foundation Office* by 5:00 p.m. on March 31, 2010 or post-marked by March 31, 2010.** No late applications will be accepted.

Mailing Address:

West Valley Hospital Foundation
PO Box 378
Dallas, OR 97338

***Physical Address:**

West Valley Hospital Administration
525 SE Washington St
Dallas, OR 97338

3. Along with the completed form, the following must be included with your application:
 - A. Copies of your most recent college or high school academic transcripts
 - B. A typed **one-page** essay, which includes a personal goal statement about your career aspirations and plans, a brief personal assessment of your strengths and weaknesses and a description of your extra-curricular and community service activities.
 - C. **One** letter of reference from a **teacher, school counselor or employer**. References from family members will not be accepted.
 - D. A current, typed resume; please include paid and volunteer work experience.

~ Please do not use staples when assembling your application packet. ~

West Valley Hospital Foundation Scholarship Application

Please Type or Print Clearly

Last Name	First Name	Middle Initial	E-mail Address	
Current Street Address		City	State	Zip
Permanent Street Address if different than above		City	State	Zip
Home Phone	Business Phone	Cell Phone or Message Phone	Length of Polk County Residency	

Please indicate the program for which you are applying for scholarship funds:

- | | | |
|---|------------------------------------|--|
| <input type="checkbox"/> Nursing – Associate Degree | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Nursing – BSN | <input type="checkbox"/> Radiology | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Nursing – MSN | <input type="checkbox"/> Imaging | <input type="checkbox"/> Other*: _____ |

* Please call the Foundation Office at 503-831-3456 to see if your program is accepted by the West Valley Hospital Foundation prior to completing your application.

Have you been accepted into that program? Yes No If not, date acceptance is expected: _____

School you plan to attend

School Financial Aid Office Address	City	State	Zip
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Credit Hours – complete one: Full time _____ # hrs Part time _____ # hrs	Year of program you will be entering: <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th <input type="checkbox"/> Other	How many more years to complete your course of study _____
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Are you an employee of West Valley Hospital? <input type="checkbox"/> Current employee <input type="checkbox"/> Past employee Position/Dept: _____	Family Member <input type="checkbox"/> Current employee <input type="checkbox"/> Past employee Name/Relationship: _____ Position/Dept: _____
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Current Employer, other than West Valley Hospital (if applicable)	Job Title	Hours worked per week
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Is working at West Valley Hospital or in the West Valley community part of your career plan? Yes No

Education Summary

Name of School	Years Attended	Credit Hrs	Degree/Major	Graduation or Anticipated date	GPA
High School					
College					
College					
Technical School					
Post Graduate					

Applicant Information			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	If divorced, <input type="checkbox"/> receiving annual spousal support \$ _____ <input type="checkbox"/> paying annual spousal support \$ _____		
Number of dependents	What are their ages?		
Applicant's Annual Income (Total household income if married) \$	Will you be receiving other financial assistance for school? <input type="checkbox"/> No <input type="checkbox"/> Yes - if yes, please complete next section		
Other Financial Assistance			
Please list all	Organization / Name	Percentage of Total Tuition Cost	
Grants			
Scholarships			
Employer Tuition Reimbursement			
Family Support (parents, relatives)			
Other			
Expenses – Please report expenses for the <u>current</u> school year			
Tuition and Fees (see college catalog)	\$	On campus housing	\$
Books and Supplies	\$	Off campus rent/utilities	\$
Uniforms and/or Equipment	\$	Food and Personal Expenses	\$
Additional factors which influence your financial capabilities that you want to share with the committee:			
Agreement			
I certify that the information I have provided is true and correct. I will notify the Foundation if this information changes.			
I understand that the purpose of this scholarship is to defray the cost of tuition and books. I understand that I am under obligation to return the full amount of my scholarship if I change my course of study to something other than a medical or medically-related field.			
I understand that I am under obligation to notify the Foundation if my student status changes from that which is indicated on this application.			
I hereby authorize the release of this application and any relevant supporting information to persons involved in the selection and awarding of scholarship recipients.			
Applicant's Signature _____ Date _____			