POLICIES OF THE SCHOLARSHIP AWARDS COMMITTEE
OF THE
ANDERSON HOSPITAL AUXILIARY

Students will be granted a $1000.00 scholarship to be applied toward educational expenses (tuition, books, and fees). These students must be legal residents of the state of Illinois and reside in Madison, St. Clair or adjacent counties. All Anderson Hospital employees, however, qualify regardless of place of residence. The college to be attended need not be an Illinois institution, however, it must be accredited.

To be eligible for consideration, students must be enrolled at least half-time in a health occupation program at an accredited college or university.

Each applicant must provide proof of acceptance into a program preparing them for a health-related occupation and/or completion of a health-related degree.

Student selections will be made annually by the Auxiliary Scholarship Committee. Previous winners will also be considered.

If the recipient's course of study is changed from a health-related occupation, or if he/she withdraws from school, all funds remaining in the account must be returned to the Auxiliary.

All information provided will be strictly confidential. Please ensure that you have completed all application pages front and back. A checklist can be found in this package.

Revised 1/7/2020

REQUIREMENTS

Check off the requirements as completed and attach to application.

_____ 1. Type or print in ink the attached application.

_____ 2. Complete (before a notary public) the attached Affidavit of Educational purpose.

_____ 3. Submit copies of your high school transcript (if less than 30 college credits completed) and/or college transcripts.

_____ 4. Submit applicant's latest federal income tax return.

_____ 5. Write a letter stating why you want to receive the Anderson Hospital Scholarship and how you intend to use the funds.

_____ 6. Submit a copy of your acceptance into a Health Occupation Program from the college of your choice.

_____7. GPA--Minimum of 3.0 on a 4.0 grading scale.

_____8. Parental information: If claimed as a dependent, this information **must be** completed.

Mail **ALL** of the above requirements by Monday, June 3, 2024 to:

Cheryl Pace, Scholarship Chairperson
Anderson Hospital
6800 State Route 162
Maryville, IL 62062

Unless **ALL** of the above requirements are received by due date, your application will not be considered for the scholarship.

Anderson Hospital Auxiliary Scholarship Application

Name:_____

Street Address:_____

City: _____ State:_____ Zip: _____ County: _____

Date of Birth: _____ Telephone Number: _____

Email: _____ Citizenship: U.S._____ Other: _____

Applicant's employer: _____ Yearly Income: _____

Are you married? _____ Yes _____ No

If Yes, Spouse's name: _____

Spouse's employer: _____ Yearly Income: _____

Number of persons in applicant's household (including self): _____

Number of persons in applicant's family in college (including self): _____

Do you live with your parent(s)/guardian? _____ yes _____ no
(if yes, complete Parental Information section below)

Were you claimed as an Income Tax dependent by your parent(s)/guardian last year? ____ yes ____ no

Parental Information (complete the following if claimed as a dependent)

Parents or Guardians Name:_____

Address:_____

Father's/Guardian Employer: _____

Mother's/Guardian Employer: _____

Parents Total Yearly Income (Gross) _____<$100,000 _____ $100,001 - $150,000 _____ >$150,000

Education: High School Attended: _____

High School Graduation Date:_____ High School Cumulative GPA: _____

Revised 1/7/2020

List Colleges/Universities attended, GPA, and degrees received:

_____ _____ _____

_____ _____ _____

_____ _____ _____

College you will be attending in upcoming academic year: _____

Expected Graduation Date:_____ Major: _____

Final academic goal: _____

List all activities and awards you have received: (add additional sheet if required):

_____

_____

_____

List financial assistance and/or scholarships, including amount, you received last academic year.

_____

_____

_____

List all financial aid or scholarship assistance you have applied for, have received, or expect to receive for the upcoming academic year. Include value of each.

_____

_____

_____

I certify that the statements and information are true and accurate to the best of my knowledge. I understand that **any false or incomplete information** could result in my not being considered for this award. I also understand that my rights of privacy will not be abused and that this award is not based on sex, race, color, religion or national origin.

Date_____ Signature_____

AFFIDAVIT OF EDUCATIONAL PURPOSE

I hereby affirm that any funds received from the Anderson Hospital Auxiliary will be used solely for college expenses (tuition, books, fees) at

_____

Name of College/University

APPLICANT: **SIGN IN THE PRESENCE OF A NOTARY PUBLIC**

_____ _____

Applicant's Signature Date

Subscribed and sworn before me this _____day of _____, 2024

_____

Notary Public

_____

Address

_____

Commission Expires Seal

Revised 1/7/2020