

**GOLDEN VALLEY MEMORIAL HOSPITAL
APPLICATION FOR ZETA GILVIN EDUCATIONAL SCHOLARSHIP**

FULL NAME OF APPLICANT: _____

STREET ADDRESS: _____

CITY/STATE, ZIP CODE: _____ PHONE #: _____

NAME OF SPOUSE, PARENTS OR GUARDIAN: _____

ADDRESS: _____ PHONE #: _____

NAME OF HIGH SCHOOL YOU LAST ATTENDED: _____

ADDRESS: _____ PHONE #: _____

YEAR THAT YOU GRADUATED: _____ G.P.A. UPON GRADUATION: _____

ACT SCORE: _____ CLASS RANK: _____

LIST OF SCHOOL ACTIVITIES IN WHICH YOU HAVE BEEN INVOLVED AND AWARDS YOU HAVE RECEIVED: _____

WILL YOU BE RECEIVING OTHER SCHOLRSHIPS? IF YOU KNOW OF ANY, PLEASE LIST THEM:

TITLE OF PRESCRIBED PROFESSIONAL HEALTH CARE PROGRAM:

NAME AND ADDRESS OF PROFESSIONAL HEALTH CARE SCHOOL TO WHICH YOU HAVE BEEN ACCEPTED: _____

YOUR SCHOOLING IS SCHEDULED TO: BEGIN: _____ BE COMPLETED: _____

LIST EMPLOYMENT HISTORY:

<u>Employer</u>	<u>Address</u>	<u>Phone #</u>	<u># Years Employed</u>	<u>Duties</u>

ZETA GILVIN EDUCATIONAL SCHOLARSHIP (Continued)

LIST THREE CHARACTER REFERENCES (Do not list relatives):

<u>Name</u>	<u>Address</u>	<u>Phone #</u>	<u>Occupation</u>
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ARE YOU, YOUR SPOUSE, PARENTS, OR GUARDIAN FINANCIALLY ABLE TO PAY YOUR FULL EXPENSE FOR THIS PROFESSIONAL HEALTH CARE TRAINING? _____ IF NO, THEN WHAT PART OR PERCENT OF THE EXPENSES COULD YOU OR THEY PAY? _____

PLEASE WRITE A BRIEF STATEMENT EXPLAINING YOUR GOAL IN ACHIEVING A CAREER IN THE MEDICAL FIELD:

SIGNATURE: _____ DATE: _____

SPECIAL INSTRUCTIONS:

1. In making application for this scholarship, you must also provide the following:
 - a) A copy of your high school transcript;
 - b) A copy of your transcript for any other post-secondary health care training you have received from an accredited institution;
 - c) A copy of your entrance examination test scores for the current program;
 - d) Proof of acceptance into the professional health care program;
 - e) A schedule of student fees and/or estimated expenses usually provided by the school;
2. All information you provide in making this application will be kept in strictest confidence and will be shared only with those individuals involved in the approval and/or payment of this scholarship unless otherwise directed by you in writing.
3. Once you have all of the required information, submit all required information to the Nursing Office and determine if there is a need to schedule an interview or mail this application to:

Assistant Administrator – Patient Care Services
Golden Valley Memorial Hospital
1600 North Second Street
Clinton, Missouri 64735