**Applicant Instructions:**

1. Applicants applying for health career scholarships must meet the following requirements:
   1. Except for PeaceHealth St. John Medical Center Caregivers, applicants must reside within the following counties: Cowlitz, Clark, Lewis, Wahkiakum, Pacific, Clatsop, or Columbia.
   2. Applicant must be pursuing an education in the medical profession. These professions must be employable by PeaceHealth St. John Medical Center. Dentistry, naturopathy, massage therapy, acupuncture, and other professions that are not employment opportunities at PeaceHealth St. John Medical Center are not eligible for consideration.
   3. High School applicants must be graduating seniors and/or GED recipients.
   4. Applicant must have a minimum cumulative GPA of 2.8 as a part-time (8 credits/quarter) or full-time student at an accredited college or university. For high school students, a minimum cumulative GPA of 3.0 is required.
   5. Applicant must provide the Friends of St. John Medical Center Scholarship Committee with a completed application, including all required documents as listed below.
      1. Application
      2. Sealed official GPA transcript
      3. Personal essay dated within 6 months
      4. Two letters of recommendation signed and on business letterhead dated within six (6) months
2. The following information must accompany the application form:
   1. Applicant’s most recent sealed *official* school transcript(s). If applicant is not currently enrolled in school, provide a transcript from the last school attended, if within the past five years.
   2. All new and returning applicants must include two new signed letters of recommendation preferably on business letterhead, dated within the past six months. Letters can be from current or former employers, teachers, etc. No relatives please.
   3. All new and returning applicants must submit a new essay dated within the last 6 months. The essay should describe your long term personal and academic goals and state how you will benefit the health care community of the Lower Columbia Region. Describe your personal strengths/skills and any other information you think will assist the committee in giving your application special consideration.
   4. All questions on the application must be completed. If an applicable question or section is left blank, the application will become ineligible for consideration.
3. The **fully** completed application and all attachments must be received by or postmarked by

**Friday, April 29, 2022**. Documents will not be accepted after this date. Please carefully review your application packet before submission. *Incomplete applications will be ineligible for consideration by the Scholarship Committee.* Friends of St. John are offering several scholarships. Winners will be notified on or after June 4, 2021.

**Mail completed application to:**

Scholarship Committee/Friends of St. John

c/o PeaceHealth St. John Medical Center

PO Box 3002

Longview, WA 98632

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1615 Delaware Street, Longview, WA 98632 360-414-7506 Phone

peacehealth.org/st-john 360-501-7594 Fax

**Please check all that apply:**

🞎 High School Student

🞎 Adult Applicant

🞎 PeaceHealth Volunteer

🞎 PeaceHealth Caregiver

🞎 Previous Friends Scholarship Recipient Year(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount(s): $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This box to be completed by Scholarship Committee ONLY.**

**Scoring Rubric:**

**Transcripts/Grades: [\_\_\_\_] 1-10**

3.76 – 4.00 = 10

3.51 – 3.75 = 8

3.26 – 3.50 = 6

3.00 – 3.25 = 4

2.99 or less = 2

**Difficulty of Course Load: [\_\_\_\_] 1-3**

**Financial Need: [\_\_\_\_] 1-3**

**Community Involvement: [\_\_\_\_] 1-3** \* Add 1 bonus point for 150+ volunteer hours.

\* Add 1 bonus point for being a PeaceHealth Volunteer.

**Essay: [\_\_\_\_] 1-3**

**Personal Strength/Leadership Skills: [\_\_\_\_] 1-5**

**Overall Quality of Application: [\_\_\_\_] 1-5**

**TOTAL SCORE: [\_\_\_\_] /32 (+2 bonus points)**

What key attributes and determining factors support your rating? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| Date: | | |
| Last Name: | First Name: | |
| Address: | | City/State/Zip Code: |
| Daytime Phone:  ( ) | Email Address: | |
| Student ID #: | Current School: | |

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|  |  |  |  |  |  |
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| EDUCATION | | | | | |
| **1.** | Are you currently enrolled in high school, college, or university? Yes 🞎 No 🞎 | | | | |
| Name of Educational Institution | |  | | |
| Address | |  | | |
|  | | |
| City | State | Zip |
| Numbers of quarters, semesters, or credits completed: | | | | |
| Cumulative Grade Point Average: | | | | |
| **Please attach current official transcript or most recent official transcript (including high school if it’s within the past 5 years) in sealed envelope from the educational institution. Printed online transcripts will not be accepted.** | | | | |
| **2.** | Are you involved in any school-related extracurricular activities? Yes 🞎 No 🞎 | | | | |
| Please list your extracurricular activities below with dates of participation. | | | | |
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| **3.** | Please list below the college, school or university in which you will be using this scholarship. | | | | |
| Name of College, School or University |  | | | |
| Address |  | | | |
|  | | | |
| City | | State | Zip |
| **4.** | In what healthcare career do you plan to major? | | | | |

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| FINANCIAL | |
| **1.** | Annual Household and/or Personal Income:  *This is the gross (pre-tax) income from all wage earners in the household over 18 years of age, including your own.*  🞎 Less than $30,000/Year  🞎 $30,000-$50,000/Year  🞎 $50,001-$75,000/Year  🞎 $75,001-$100,000/Year  🞎 $100,001-$150,000/Year  🞎 $150,001+/Year |
| **2.** | Number of People Dependent on Household Income: |
| **3.** | Are you currently employed? Yes 🞎 No 🞎 |
| Name of employer: |
| **4.** | Please describe any extenuating family/financial concerns affecting your scholarship needs (i.e. other dependents in college or private school, childcare expenses, illness in family, etc.). |
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| **5.** | Have you been granted or will you receive other sources of funding? Yes 🞎 No 🞎 |
| If yes, list the title of funding, year(s) and amount(s) granted: |
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|  |  |  |
| --- | --- | --- |
| COMMUNITY INVOLVEMENT | | |
| **9.** | Do you currently or have you volunteered in the past four years? Yes🞎 No🞎 Total hours\_\_\_\_\_\_ | |
| If yes, state name of agency, dates of service, total number of volunteer hours served, and briefly describe your responsibilities: | |
|  | |
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| ESSAY | | |
| **10.** | On a separate sheet of paper, please attach an essay to describe your long term personal and academic goals and state how you will benefit the health care community of the Lower Columbia Region. Describe your personal strengths/skills and any other information you think will assist the committee in giving your application special consideration. Your essay should be approximately 300-500 typed words and double spaced. | |
| I certify that to the best of my knowledge the information contained in this application is factual and true. I authorize the Scholarship Committee to verify the information given. | | |
| **Signature of applicant** | | **Date** |

**SCHOLARSHIP APPLICATIONS MUST BE**

**POSTMARKED OR DELIVERED NO LATER THAN FRIDAY, APRIL 29, 2022.**

**PLEASE MAIL COMPLETED APPLICATIONS TO:**

Scholarship Committee/Friends of St. John

c/o PeaceHealth St. John Medical Center

PO Box 3002

Longview, WA 98632

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