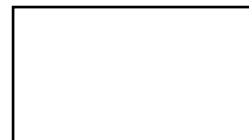


Applicant Instructions:

1. Applicants applying for health career scholarships must meet the following requirements:
 - A. With the exception of PeaceHealth St. John Medical Center Caregivers, applicants must reside within the following counties: Cowlitz, Clark, Lewis, Wahkiakum, Pacific, Clatsop or Columbia.
 - B. Applicant must be pursuing an education in the medical profession. Dentistry, naturopathy, massage therapy, acupuncture, and other professions that are not employment opportunities at PeaceHealth St. John Medical Center are not eligible for consideration.
 - C. 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.
 - D. Applicant must provide the PeaceHealth St. John Medical Center Scholarship Committee with a completed application, including all required documents as listed below.
 - E. High school applicants must be graduating seniors and/or GED recipients.
2. The following information must accompany the application form:
 - A. Applicant's most recent *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.
 - B. All new and returning applicants must include two new 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.
 - C. All new and returning applicants must submit a new essay. 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.
 - D. 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 3, 2020**. 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, up to \$5000. Winners will be notified on or after May 4, 2020.

Mail completed application to:

Scholarship Committee/Friends of St. John
c/o PeaceHealth St. John Medical Center
PO Box 3002
Longview, WA 98632



Please check all that apply:

- ☐ High School Student
☐ Adult Applicant
☐ PeaceHealth Volunteer
☐ PeaceHealth Caregiver
☐ Previous Friends Scholarship Recipient Year(s): _____ Amount(s): \$ _____

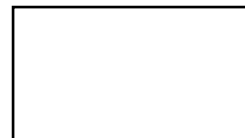
Date:	
Last Name:	First Name:
Address:	City/State/Zip Code:
Daytime Phone: ()	Email Address:
Student ID #:	Current School:

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? _____



EDUCATION

1.	Are you currently enrolled in high school, college, or university? Yes <input type="checkbox"/> No <input type="checkbox"/>			
	Name of Educational Institution			
	Address			
			City	State
	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 <input type="checkbox"/> No <input type="checkbox"/>			
	Please list your extracurricular activities below with dates of participation.			
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
4.	In what healthcare career do you plan to major?			



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.).

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:



COMMUNITY INVOLVEMENT

9.	Do you currently or have you volunteered in the past four years? Yes <input type="checkbox"/> No <input type="checkbox"/> Total hours _____
	If yes, state name of agency, dates of service, total number of volunteer hours served, and briefly describe your responsibilities:

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.
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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
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**SCHOLARSHIP APPLICATIONS MUST BE
POSTMARKED OR DELIVERED NO LATER THAN FRIDAY, APRIL 3, 2020.**

PLEASE MAIL COMPLETED APPLICATIONS TO:
PeaceHealth St. John Medical Center
Friends of St. John Scholarship Committee
PO Box 3002
Longview, WA 98632