Memorial Healthcare Foundation
PEGGY GULICK NURSING SCHOLARSHIP
RENEWAL APPLICATION
2018/2019 Award Year

The following must be completed by the <u>Applicant.</u> Please type or print information.

Applicant's Name_____
(Last Name) (First) (Middle Initial)

Address_____

City_____ **State**_____ **Zip Code**_____

County _____ **Telephone (_____)**_____

College Attending_____

City_____ **State**_____

Date Begun_____ **Full Time student? _____ Yes _____ No**

Type of Nursing Program enrolled in: _____ADN _____BSN

Expected date of degree completion_____

Describe your work experience (if any) of the past year. Indicate dates of employment (attach additional sheet(s) if necessary).

Company	Position	Date From	Date To	Supervisor

List all collegiate activities (if any) in which you have participated during the past year. Include any special awards, honors and offices held (attach additional sheets if necessary).

_____

_____

_____

List all community activities (if any) in which you have participated during the past year. Include any special awards, honors and offices held (attach additional sheets if necessary).

_____

_____

_____

List any special skills or interests that you have. Include any special awards or honors you've received (attach additional sheets if necessary).

_____

_____

_____

The Peggy Gulick Nursing Scholarship requires that recipients enter into an Employment Service Agreement with Memorial Healthcare agreeing to secure employment with Memorial Healthcare for a period of two (2) years. Repayment of scholarship monies will be expected if the terms of the Employment Service Agreement are not fulfilled.

The undersigned hereby acknowledges that the information provided in this application, including any enclosed documents, is true and correct to the best of their knowledge.

_____ _____

Applicant Signature **Date**

Memorial Healthcare Foundation
PEGGY GULICK NURSING SCHOLARSHIP
CONFIDENTIAL EMPLOYER RECOMMENDATION
2018-19 Award Year

Applicant's Name_____
(Last Name) (First) (Middle Initial)

To the Applicant: Please print your name above and sign the statement below. The Family Educational Rights and Privacy Act of 1974 and its amendments guarantee students access to education records concerning them. Students are permitted to waive their right of access to recommendations. A waiver of their right of access may permit recommenders to submit a more candid evaluation. The following signed statement indicates the wish of the applicant with respect to this recommender's recommendation.

☐ *I waive my right of access to the following recommendation.*
☐ *I do not waive my right of access to the following recommendation. I understand that under the law my waiver provides that I only have access to this recommendation.*

_____ _____
Signature ***Date***

To the Recommender: The person whose name appears above is applying for a scholarship with the purpose of encouraging scholarship recipients to pursue studies in select health care disciplines. The applicant has requested that your evaluation be included as part of the information upon which the selection decision will be based. We value your direct contact with the applicant and will appreciate your responses to the following questions as candidly and specifically as possible. Your responses will assist the Scholarship Committee in the evaluation of the applicant's qualifications for the receipt of a scholarship. We realize the amount of time and care necessary to complete a thoughtful recommendation and are grateful for your assistance.

Our application procedure requires that the applicant gather all documents including recommendations and submit a complete set of materials with the application. This system allows the applicant to know the completed application has been submitted and facilitates our control over materials. Please enclose the completed recommendation in an envelope. Please seal the envelope, sign across the seal, and return it to the applicant so that it can be submitted with the application.

Name of Recommender (print or type) _____

Position or Title _____

Organization _____

Address

_____

Telephone Number _____ **Facsimile Number** _____

Please rate the applicant in the following attributes, relative to others whom you have known in a similar capacity.

	Outstanding	Strong	Average	Fair	Poor	Not Observed
Integrity						
Motivation & Drive						
Leadership Potential						
Imagination & Creativity						
Self-Confidence						
Ability to Work w/Others						
Intellectual Ability						
Ability in Oral/Written Expression						

Please address the following items in a narrative form and include any other information that will help the Scholarship Committee make its decision:

- **How long and in what connection have you known the applicant?**
- **What do you know of the applicant's future academic plans?**
- **What special qualities does the applicant possess which would contribute to success in the study of a health care discipline?**
- **What qualities should the applicant improve upon for success in the study and a subsequent career in a health care discipline?**

Please check one:

_____ I *strongly recommend* this applicant for receipt of a Memorial Healthcare Foundation Scholarship.

_____ I *recommend* this applicant for receipt of a Memorial Healthcare Foundation Scholarship.

_____ I *recommend with reservation* this applicant for receipt of a Memorial Healthcare Foundation Scholarship.

_____ I *do not recommend* this applicant for receipt of a Memorial Healthcare Foundation Scholarship.

Signature _____ Date _____

Memorial Healthcare Foundation
PEGGY GULICK NURSING SCHOLARSHIP
CONFIDENTIAL <u>ACADEMIC</u> RECOMMENDATION
2018/2019 Award Year

Applicant's Name_____
(Last Name) (First) (Middle Initial)

To the Applicant: Please print your name above and sign the statement below. The Family Educational Rights and Privacy Act of 1974 and its amendments guarantee students access to education records concerning them. Students are permitted to waive their right of access to recommendations. A waiver of their right of access may permit recommenders to submit a more candid evaluation. The following signed statement indicates the wish of the applicant with respect to this recommender's recommendation.

☐ *I waive my right of access to the following recommendation.*
☐ *I do not waive my right of access to the following recommendation. I understand that under the law my waiver provides that I only have access to this recommendation.*

_____ _____
Signature ***Date***

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_____ I *recommend with reservation* this applicant for receipt of a Memorial Healthcare Foundation Scholarship.

_____ I *do not recommend* this applicant for receipt of a Memorial Healthcare Foundation Scholarship.

Signature _____ Date _____

Memorial Healthcare Foundation
PEGGY GUICK NURSING SCHOLARSHIP
TRANSCRIPT REQUEST
2017/2018 Award Year

To the Applicant: Print the information requested below and send this form to your College or University registrar.

Name_____
(Last Name) (First) (Middle Initial)

Student Number _____

School_____

Dates of Enrollment_____ **Degree and Year**_____

I hereby request the release of an official transcript and comments on my academic record to the Memorial Healthcare Foundation Scholarship Committee.

_____ **Date**_____
Signature

_____ **Date**_____
Guardian Signature ***(if Applicant is under 18 years of age)***

To the Registrar: The person named above is applying for a Memorial Healthcare Foundation Scholarship Award and we are asking your assistance in our effort to provide transcript control in the application process. Please complete this form and enclose it with an official copy of the applicant's academic transcript in an envelope. Please seal the envelope, sign across the seal, and return it to the applicant so that it can be submitted with the application. If this procedure is contrary to your policy, please send the transcript directly to the Memorial Healthcare Foundation Office, Scholarship Committee, 1637 W. Main Street, Owosso, MI 48867. Thank you for your cooperation.

_____ **Date**_____
Signature and title of College or University official