

**Memorial Healthcare Foundation
MARGARET S. GULICK NURSING SCHOLARSHIP
APPLICATION
2022/2023 Award Year**

The following must be completed by the Applicant. 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
MARGARET S. GULICK NURSING SCHOLARSHIP
CONFIDENTIAL EMPLOYER RECOMMENDATION
2022-23 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
MARGARET S. GULICK NURSING SCHOLARSHIP
CONFIDENTIAL ACADEMIC RECOMMENDATION
2022/2023 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.
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Signature

Date

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Please check one:

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- _____ 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
MARGARET S. GULICK NURSING SCHOLARSHIP
TRANSCRIPT REQUEST
2022/2023 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.

Signature **Date** _____

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

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.

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