

SANFORD HEALTH NETWORK

2019 SCHOLARSHIP APPLICATION

Sanford Health Network is pleased to offer a \$2,000 scholarship opportunity to students pursuing a post-secondary degree in a health care-related field. By offering this scholarship, we are making an investment in our region's future workforce and the communities we serve.

STUDENT QUALIFICATION REQUIREMENTS

- Applicants should have an affiliation with a participating Sanford Health Network facility.
- Participating facilities include:
 - Community Memorial Hospital - Burke, SD
 - Murray County Medical Center
 - Ortonville Area Health Services
 - Perham Health
 - Pioneer Memorial Hospital
 - Sanford Aberdeen Medical Center
 - Sanford Canby Medical Center
 - Sanford Canton-Inwood Medical Center
 - Sanford Chamberlain Medical Center
 - Sanford Clear Lake Medical Center
 - Sanford East Grand Forks
 - Sanford Health Broadway Clinic - Alexandria, MN
 - Sanford Health Detroit Lakes Clinic and Same Day Surgery
 - Sanford Health Hillsboro Care Center
 - Sanford Jackson Medical Center
 - Sanford Luverne Medical Center
 - Sanford Medical Center Mayville
 - Sanford Medical Center Thief River Falls
 - Sanford Rock Rapids Clinic
 - Sanford Sheldon Medical Center
 - Sanford Tracy Medical Center
 - Sanford Vermillion Medical Center
 - Sanford Webster Medical Center
 - Sanford Westbrook Medical Center
 - Sanford Wheaton Medical Center
 - Sanford Worthington Medical Center
 - Windom Area Hospital
 - Winner Regional Healthcare Center
- Accepted into a healthcare program at an accredited, post-secondary institution.
- Cumulative grade point average of 3.0 or greater, calculated on a 4.0 grading scale.
- The applicant must send an official transcript of grades from their last completed semester of study. The transcript must show current grade point average.

APPLICATION REQUIREMENTS MUST INCLUDE:

- Scholarship essay addressing all of the following:
 - Reasons for choosing a healthcare profession
 - Career goals after graduation
 - Extracurricular activities and community involvement
- Three professional references. Provide the attached form to your reference to fill out and return to you in a sealed envelope to submit with your completed application.
- Mail completed applications and documentation to:
 - Sanford Health LEAD
 - Attn: Laura Woitte-Currier Route: 5203
 - PO Box 5039
 - Sioux Falls, SD 57117-5039

A completed application and the required supplemental documentation are due by April 12, 2019.

SELECTION PROCESS

Sanford Health Network scholarship recipients will be selected based upon application information, GPA, essay, references and overall rate of success. All applicants will receive written notification of the scholarship decisions.

AWARD DETAILS

- Students may apply each year they qualify. \$4,000 lifetime scholarship award limit.
- Recipients will incur the applicable taxes and must complete a 1099 prior to disbursement.

CONTACT INFORMATION | E-mail: educationalassistance@sanfordhealth.org | Phone: (605) 312-9232



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Name _____ Last 4 digits of SSN _____

E-mail _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Healthcare Program Enrolled In _____ Anticipated Graduation Date _____

School Name _____

School Address _____ City _____ State _____ Zip _____

Education (i.e., high school, college, vocational school):

| Name of School | City/State | Graduation Date | Degree |
|----------------|------------|-----------------|--------|
|----------------|------------|-----------------|--------|

1. _____

2. _____

3. _____

List the participating Sanford Health Network facility you are affiliated with and the nature of your affiliation.

Have you ever been employed with Sanford Health or any of its affiliates? _____

Dates _____ to _____ Title _____ Location _____

Dates _____ to _____ Title _____ Location _____

Dates _____ to _____ Title _____ Location _____

Have you ever worked in healthcare? _____

Dates _____ to _____ Title _____ Company _____

Dates _____ to _____ Title _____ Company _____

Dates _____ to _____ Title _____ Company _____

Have you previously received a scholarship from Sanford Health? _____

Which one? _____ When? _____ \$ _____

Which one? _____ When? _____ \$ _____

I certify that the information in this application is complete and accurate. I understand that any falsification of the required information will disqualify me from receiving scholarship funds.

APPLICANT'S SIGNATURE _____ DATE _____

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Applicant Name _____

How long have you known this applicant? _____

In what capacity have you known this applicant?

- | | |
|---|--|
| <input type="checkbox"/> Instructor (current or past) | <input type="checkbox"/> Mentor (coach, church leader, etc.) |
| <input type="checkbox"/> Supervisor (current or past) | <input type="checkbox"/> Community leader |
| <input type="checkbox"/> Co-worker (current or past) | <input type="checkbox"/> Other _____ |

| | Below Average | Average | Above Average | Excellent | No Basis for Opinion |
|-----------------------------|---------------|---------|---------------|-----------|----------------------|
| Scholastic ability | | | | | |
| Initiative | | | | | |
| Ability to work with people | | | | | |
| Confidence | | | | | |
| Acceptance of criticism | | | | | |
| Self-discipline | | | | | |
| Dependability | | | | | |
| Honesty | | | | | |
| Reaction to stress | | | | | |
| Efficiency | | | | | |
| Accountability | | | | | |
| Organizational ability | | | | | |
| Ability to make decisions | | | | | |
| Interest in learning | | | | | |

Overall Evaluation: *(Circle one)* Highly Recommend Recommend Recommend with Reservations

Comments _____

Signature _____ Date _____

Job Title _____ Organization _____

Please complete this form and return it to the applicant in a sealed envelope.