SSMHealth
Ripon Community Hospital

2024 Scholarship Application

SPONSORED BY THE RIPON COMMUNITY HOSPITAL AUXILIARY

1 PERSONAL DATA

Name: _____ Telephone Number: (_____) _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____

Parents or Guardians: _____

Number of Siblings and Ages: _____

Name of School Currently Enrolled In: _____

Healthcare Career You Are Considering: _____

Institutions for Which You Have Been Accepted: _____

_____

_____

2 FINANCIAL DATA

To enable the committee to select scholarship recipients, it is necessary to evaluate financial need, as well as scholastic achievements, character, etc. For this reason, you are asked to provide the following information which will be treated as confidential.

A. List your total expenses for your first year of schooling using cost data provided by the institution you plan to attend.

Tuition _____ Books _____

Housing _____ Other _____

B. How much can you provide toward this from your own earnings and/or savings? $ _____

C. How will your parents support your education? _____

3 SHORT WRITTEN ESSAY (Answer the following questions, not exceeding two typewritten double-spaced pages.)

A. Why are you choosing to enter this healthcare field?
B. To date, what have you done to demonstrate your interest in this health field?
C. Describe how you have been a leader in school or in your community.
D. How do you plan to finance your education?

4 CO-CURRICULAR & SERVICE ACTIVITIES

List the co-curricular and service activities in which you participated. Include any offices held or honors received while in high school.

ACTIVITIES	YEARS PARTICIPATED: FR, SO, JR, SR

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5 WORK EXPERIENCE List any jobs held.

EMPLOYER	POSITION	DATES

6 REFERENCES

Please list the names of three people as references for you. No more than one person may be a teacher in the high school you are attending. Your references may be contacted by the committee.

NAME	OCCUPATION	RELATIONSHIP	PHONE

I AFFIRM THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: _____ **Date:** _____

All portions of this application must be completed and mailed with your essay, as well as a transcript of your high school grades, to the address listed below:

CONTACT: Jason Blonigen
Volunteer Services Coordinator
SSM Health Ripon Community Hospital
845 Parkside Street
Ripon, WI 54971
920-745-3670

ALL APPLICATIONS MUST BE POSTMARKED NO LATER THAN MARCH 8, 2024.

Scholarships awarded will be directed to the educational institution on behalf of the student.