



SSMHealth

St. Mary's Hospital Foundation

Rhonda Shimmens Scholarship

Application Deadline - 4:30 p.m. – October 7th

APPLICANT INFORMATION				
Last Name:		First Name:		Middle Initial:
Address:			Telephone ()	
City:		State:	Zip:	County:
E-mail:			SSN#:	
Are you eligible to work in Missouri two years following completion of the program? <input type="checkbox"/> Yes <input type="checkbox"/> No				
EDUCATION				
Circle the highest grade completed: High School: 9 10 11 12 GED College: 1 2 3 4				
PROGRAM TYPE AND COURSE				
Indicate type and name of the course/program in which you are enrolled in or to which you have been accepted				
<input type="checkbox"/> Independently established course _____				
<input type="checkbox"/> Professional Accreditation _____				
<input type="checkbox"/> Continuing Education _____				
<input type="checkbox"/> Other Licensed or Registered Profession _____				
Provide a brief description of the course or program:				
Name of Program/School/College/Institute:			Address:	
Contact Person:		Title of Contact Person:		Telephone ()
Program Start Date:		Program End Date:		Total cost of program/course?
** PLEASE SUBMIT AN ORIGINAL TRANSCRIPT WITH THIS APPLICATION** ** Attach a schedule of fees and proof of enrollment or acceptance **				
EMPLOYMENT				

All information is confidential and for programmatic purposes only.

Are you presently employed by St. Mary's? <input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date:	Do you plan to remain with St. Mary's? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Department/Unit:	Ext:
May we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Work Supervisor or Director:	Ext:

PERSONAL STATEMENT

On a separate sheet, submit a personal statement describing your commitment to SSM Health St. Mary's Hospital – Jefferson City. Include information detailing the need and benefits of the training/education. This statement is not to exceed one single-spaced typewritten page. **On a separate sheet list your extracurricular, community, volunteer or health care activities.** (It is important for the selection committee to have this information from all applicants.)

REFERENCE (Current Employer)

Applicant must be an employee in good standing for 12 consecutive months at the time of application. Include at least one letter of reference from a work supervisor or director.

APPLICATIONS MUST BE RECEIVED BY 4:30 P.M. CDT, October 7th .
INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED. QUESTIONS REGARDING THE APPLICATION AND SELECTION PROCESS SHOULD BE DIRECTED TO THE ST. MARY'S FOUNDATION DEVELOPMENT OFFICE AT 573-681-3742 or email at tori.baker@ssmhealth.com

I certify that the information contained in this application is true, complete and correct to the best of my knowledge, and that all funds will be used for educational-related expenses. I hereby authorize the release of personal, scholastic and financial information related to my educational status from any academic institution I have attended in the past, am currently enrolled or may be enrolled as a student in the future, to the St. Mary's Foundation Scholarship Committee.

Signature of Applicant:

Date:

NOTE: This scholarship program is a competitive process, and only eligible applications will be evaluated. All eligible applications may not receive funding. **The scholarship application must be completed in its entirety to be eligible for consideration.**