

1 PERSONAL DATA

Name: _____ Telephone Number: (_____) _____

Address: _____ County: _____

City: _____ State: _____ Zip: _____

Parents or Guardians: _____

Occupation of Father: _____ Occupation of Mother: _____

Number of Siblings and Ages: _____

Name of School Currently Enrolled In: _____

Health Care Career You Are Considering: _____

Institutions for Which You Have Applied or Are Currently Enrolled At: _____

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 2024-2025 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 much will your parents provide financially per year? \$ _____

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

- A. Why are you choosing to enter this health care field?
- B. To date, what have you done to demonstrate your interest in this health field?
- C. Describe how you have made a difference in school or in your community.
- D. How do you plan to finance your education?
- E. Are you, or will you be, a first-generation college student?

4 CO-CURRICULAR & SERVICE ACTIVITIES

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

ACTIVITIES:	YEARS PARTICIPATED:

2025 SCHOLARSHIP APPLICATION

SPONSORED BY THE RIPON COMMUNITY
HOSPITAL MEDICAL STAFF

5 WORK EXPERIENCE List any jobs held.

JOB	DATE

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	ADDRESS & ZIP	TELEPHONE

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: Anna Thomas
Medical Staff Office
430 E. Division Street
Fond du Lac, WI 54935

ALL APPLICATIONS MUST BE POSTMARKED NO LATER THAN MARCH 15, 2025.

Scholarships awarded will be directed to the student's high school or educational institution.