RUTH HOLLIS SCHOLARSHIP

Pembina County Memorial Hospital Foundation Application

Please attach 2x3 photograph

Name: _____

Address: _____

Phone:_____

Where are you in your education? (Please select)

- ☐ High School Graduate
- ☐ First/Second Year College Student with Healthcare Emphasis
- ☐ College Student Accepted in Healthcare Program
- ☐ Adult Continuing Higher Education in Healthcare
- ☐ PCMHA Employee Continuing Higher Education in Healthcare

*Employees are not eligible if using 7.03 employee pursued education

What is your program of study?

What institution are you attending?

Have you been accepted into this program and registered for degree specific courses?

Education

Please provide documentation via transcripts

High School Name: _____ GPA: _____ Date: _____

College Name:_____ GPA:_____ Date: _____

Major:_____. Minor: _____.

College Name:_____ GPA:_____ Date: _____

Major:_____. Minor: _____.

Community Involvement, Memberships in Organizations, Leadership Positions

(please include role(s) and dates of service)

_____

_____

_____

References

Must not be family, minimum of three, may include letter which increases merit points for scholarship.

1. **Name, Address, Phone: _____**
2. **Name, Address, Phone: _____**
3. **Name, Address, Phone: _____**

Essay

- **Please state your healthcare career plans.**
- **The reason why you want to be in healthcare.**
- **Career goals following completion of education.**
- **What your connection is with the Pembina County service area.**
- **How you believe this scholarship can assist you.**
- **Essay to be typed, one page in length, MLA format.**

Agreement

It is my intention to complete my education as outlined in this application.
I agree I am to inform the foundation immediately if any decision I may make concerning changes in my education plans.
I understand that this scholarship will be discontinued if my plans change to the extent of the purpose of this scholarship are not met.
I further agree that this application and all credentials submitted by me and others on my behalf will remain the property of the Ruth Hollis Healthcare Scholarship Foundation and be used only for the purpose of evaluating my application for this scholarship.
I agree to allow my name and photo provided to be used in regional publication and digital media if I am chosen to be a recipient of this award.

Applicant Signature: _____ Date:_____

*All scholarship recipients will be notified in writing.

Please send application and correspondence by April 1st to:

Ruth Hollis Scholarship Fund
P.O. Box 380
Cavalier, ND
58220