

LABETTE HEALTH FOUNDATION 2010 SCHOLARSHIP PROGRAM

DEFINITION:

The Scholarship program, established by the Labette Health Foundation, is a program of financial assistance granted to **full-time college students who have been admitted to a health related program.**

PURPOSE:

The scholarship program is in operation in order to:

1. Assist students who possess a financial need and who are pursuing courses full-time in health care.
2. Interest college students in working at Labette Health during their education and/or after graduation.

ELIGIBILITY:

1. The individual must live in Southeast Kansas or an adjacent area, and be enrolled as a full-time student, **AND PROVIDE PROOF OF ADMISSION TO A HEALTH RELATED PROGRAM** in a two or four year college or University.
2. The individual must possess the personality traits and characteristics which the selection committee feels are indicative of a person who will complete the training and pursue the profession selected.
3. The individual must demonstrate a financial need.

SCHOLARSHIP AMOUNT:

Scholarship amounts will be determined annually by the Foundation Board. **The scholarship will be paid to the individual applicant at the Annual Scholarship Luncheon hosted by the Labette Health Foundation. Specific information regarding the luncheon will be provided to applicants in their award letter.**

APPLICATION PROCESS:

It is the responsibility of the applicant to provide a complete application to the Foundation by June 15, 2010, including all transcripts and references. *The Foundation Office will not inform applicants if their application is incomplete.*

A cover letter must be included stating career goals and needs.

If the student is to be considered for an additional year, he/she must reapply.

****APPLICATIONS WILL BE ACCEPTED BETWEEN APRIL 1 AND JUNE 15, 2010**

To: Labette Health Foundation Scholarship Applicant

From: Labette Health Foundation

Please use this checklist to be certain that all information has been completed and submitted to the Labette Health Foundation by June 15, 2010. The Foundation will not consider incomplete applications, and will not notify the applicant if all information is not received.

The applicant may call the Labette Health Foundation at 620-820-5243 or 620-820-5180 to verify that all information is received and complete.

Thank you in advance, for submitting your completed application.

_____ **Cover Letter Submitted**
_____ **Completed Application Submitted**
_____ **Financial Information Submitted**
_____ **Proof Of Admission To A Health Related Field Submitted**
_____ **High School Transcript Submitted**
_____ **College Transcript Submitted**
_____ **#1 Reference Received**
_____ **#2 Reference Received**
_____ **#3 Reference Received**

**LABETTE HEALTH FOUNDATION
SCHOLARSHIP APPLICATION**

NAME _____ TELEPHONE _____

ADDRESS _____ DATE OF BIRTH _____

HIGH SCHOOL ATTENDED _____ LOCATION _____

DATE OF GRADUATION _____ GRADEPOINT AVERAGE* _____

A.C.T. COMPOSITE GRADE _____ RANK IN CLASS _____ NUMBER IN CLASS _____

HAVE YOU ATTENDED COLLEGE? _____ NAME AND LOCATION OF COLLEGE ATTENDED _____

_____ COLLEGE CREDITS _____

COLLEGE GRADE POINT AVERAGE* _____

STUDENT MUST SUBMIT A HIGH SCHOOL AND COLLEGE TRANSCRIPT

LIST OTHER SCHOLARSHIPS AND/OR FINANCIAL AID YOU WILL RECEIVE, IF ANY:

SCHOLARSHIP/FINANCIAL AID	SOURCE	APPROXIMATE AMOUNT
_____	_____	_____
_____	_____	_____

HONORS OR DISTINCTIONS RECEIVED _____

HEALTH RELATED FIELD TO WHICH YOU HAVE BEEN ACCEPTED _____

SCHOOL TO WHICH YOU HAVE BEEN ACCEPTED _____

TUITION COST PER SEMESTER _____ BOOK AND CLASS MATERIALS FEE _____

I, _____, give my consent to be recognized publicly if I am awarded a scholarship by the Labette Health Foundation.

Signature _____ Date _____

THREE LETTERS OF REFERENCE ARE REQUIRED BY JUNE 15, 2010**. ONE OF THOSE MAY BE A FAMILY MEMBER. LIST THE THREE REFERENCES:

1. _____ 2. _____ 3. _____

****LABETTE HEALTH FOUNDATION RESERVES THE RIGHT TO VERIFY REFERENCES.**

CONFIDENTIAL REFERENCE

Please complete and return by June 15, 2010 to ensure that the applicant is considered for a scholarship.

Name Of Scholarship Applicant _____

Your Name _____ Address _____

Relationship To Applicant: Employer _____, Company Name _____
Teacher _____ Friend _____ Co-Worker _____ Other _____

Please Check The Items That Most Accurately Describes The Applicant. If You Are Unable To Answer, Or No Opinion Has Been Formed, Please Leave Blank.

Personality.....Reserved _____ Average _____ Outgoing _____

Character.....Weak _____ Average _____ Outstanding _____

Appearance.....Careless _____ Acceptable _____ Impressive _____

Dependability.....Doubtful _____ Dependable _____ Excellent _____

Leadership.....Passive _____ Contributing _____ Outstanding _____

Cooperative.....Insufficient _____ Average _____ Exceptional _____

Initiative.....Conforms _____ Self-Reliant _____ Creative _____

Conduct.....Poor _____ Good _____ Excellent _____

How Long Have You Known The Applicant? _____

If You Had The Opportunity To Employ This Person, Would You Do So? _____

Would You Care To Make Any Comments On Need For Financial Assistance? _____

How Would You Rate The Applicants General Academic Ability?

Outstanding _____ Average _____ Poor _____ No Opportunity To Observe _____

Other Comments: _____

Return This Form To:

Labette Health Foundation
1902 S. US Hwy 59
Parsons, KS 67357

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