



AUXILIARY SCHOLARSHIP PROGRAM

DEFINITION:

The scholarship program, established by the Labette Health Auxiliary, is a program of financial assistance granted to college students who are in pursuit of training/education in a health care field.

PURPOSE:

The scholarship program is in operation in order to:

1. Assist students financially 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. Individual must be at least seventeen (17) years of age, be enrolled as a full time student (12 hours), AND PROVIDE PROOF OF ADMISSION TO A HEALTH RELATED FIELD PROGRAM in a two or four year college or university in Kansas.
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:

Scholarships amounts will be determined annually by the Auxiliary Board. The scholarship will be paid directly to the school. The scholarship can be used for tuition, fees, textbooks and classroom needed materials.

APPLICATION PROCESS:

1. The individual is requested to fill out an application. If a student is to be considered for an additional year, he/she must reapply.
2. Application **MUST INCLUDE**:
 - A. Application Form
 - B. Transcript of Grades (high school and college)
 - C. Copy of Acceptance of Admission to Health Related Program
 - D. Two (2) letters of reference (no family members)
 - E. Cover letter indicating your career goals and needs.
3. Deadline is June 15 – **ONLY FULLY COMPLETED APPLICATIONS WILL BE REVIEWED. WE WILL NOT CONTACT YOU IF THE APPLICATION IS INCOMPLETE. This includes your reference letters.**

SEND COMPLETED FORMS TO:

Labette Health Auxiliary
1902 S. Highway 59
Parsons, KS 67357
(620)820-5240

AUXILIARY SCHOLARSHIP APPLICATION

APPLICANT'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ TELEPHONE NUMBER _____

HIGH SCHOOL ATTENDED _____ LOCATION _____

DATE OF HIGH SCHOOL GRADUATION _____ HAVE YOU ATTENDED COLLEGE? _____

NAME OF COLLEGE ATTENDED _____ COLLEGE CREDITS _____

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 TO _____

SCHOOL TO WHICH YOU HAVE BEEN ACCEPTED TO _____

TUITION COST PER SEMESTER _____ ESTIMATED COSTS FOR BOOKS/MATERIALS _____

PLEASE LIST YOUR TWO REFERENCES (Cannot be family members)

1. _____ 2. _____

Labette Health Auxiliary reserves the right to verify references.

I, _____, verify that the information stated in this application is true and am aware that only completed applications will be considered. I also give my consent to be recognized publically if I am awarded a scholarship by the Labette Health Auxiliary.

YOUR SIGNATURE _____ DATE _____

FINANCIAL INFORMATION
(Information is strictly confidential)

YOUR MARITAL STATUS: SINGLE__MARRIED__SEPARATED__DIVORCED__WIDOWED__

IF YOU ARE SINGLE, UNDER THE AGE OF TWENTY-ONE AND LIVING AT HOME, PLEASE INCLUDE THE FINANCIAL INFORMATION OF YOUR PARENTS/GUARDIAN. **IF YOU ARE MARRIED, YOU MUST INCLUDE THE FINANCIAL INFORMATION FOR BOTH YOU AND YOUR SPOUSE.**

NUMBER OF CHILDREN LIVING AT HOME_____

HOUSEHOLD YEARLY INCOME:

UNDER \$20,000 _____

\$20,000-\$30,000 _____

\$30,000-\$40,000 _____

\$40,000-\$50,000 _____

\$50,000-\$60,000 _____

\$60,000-\$70,000 _____

ABOVE \$70,000 _____

WILL THE APPLICANT BE EMPLOYED DURING SCHOOL_____

If yes, where _____ Full Time _____ Part Time _____

EMPLOYMENT: List below your work experiences starting with your present or last place of employment:

1. Name & address of employer: _____

Date employed: from _____ to _____

Reason for leaving: _____

2. Name & address of employer: _____

Date employed: from _____ to _____

Reason for leaving: _____

CLOSING DATE FOR COMPLETED APPLICATIONS IS JUNE 15

Return application to:
Labette Health AUXILIARY
1902 South Highway 59
Parsons, KS 67357
(620) 820-5240

EQUAL OPPORTUNITY SCHOLARSHIP



**AUXILIARY SCHOLARSHIP PROGRAM
CONFIDENTIAL REFERENCE**

NAME OF APPLICANT _____

YOUR NAME _____ RELATIONSHIP TO APPLICANT _____

What best describes the applicant on the following. If you are unable to answer or no opinion has been formed, please leave blank.

- PERSONALITY..... Poor___Average___Excellent___
- 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? _____

HOW WOULD YOU RATE THE APPLICANT'S GENERAL ACADEMIC ABILITY?

No opportunity to observe___Poor___Average___Outstanding___

DO YOU FEEL THAT THIS APPLICANT IS IN NEED OF FINANCIAL ASSISTANCE? PLEASE EXPLAIN.

OTHER COMMENTS ABOUT THE APPLICANT IS REQUIRED.

**Please return this form, before June 15, to:
(Do not give to the applicant)**

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