LABETTE HEALTH FOUNDATION
2025 SCHOLARSHIP PROGRAM

DEFINITION:

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

PURPOSE:

The scholarship program is an effort to:

1. Assist students who possess a financial need **and** 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, in Labette Health's service area, and be enrolled as a full-time student for the upcoming academic year, **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.
4. The individual must live in Kansas within a 75-mile radius of Parsons, and must be a graduate of an area high school.
5. Employees of Labette Health **are** eligible.

SCHOLARSHIP AMOUNT:

Scholarship amounts will be determined annually by the Foundation Board. **The scholarship will be paid to the successful applicant after receipt of proof of college enrollment and attendance 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 16, 2025, including all transcripts and references.

The Foundation Office will <u>not</u> inform applicants if their application is incomplete.

Please include a cover letter stating career goals and needs.

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

****APPLICATIONS WILL BE ACCEPTED UNTIL JUNE 16, 2025****

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 16, 2025. 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 to verify that all information is received and completed.

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**
(If previously submitted within the last 1 to 2 years and program of study remains the same this is not necessary)

_____**High School Transcript Submitted**
(If previously submitted in last 1 to 2 years this is not necessary)

_____**College Transcript Submitted**
(Does not need to be official transcript, copies are acceptable)

_____**#1 Professional Reference Received**

_____**#2 Professional Reference Received**

_____**#3 Professional Reference Received**

LABETTE HEALTH FOUNDATION
SCHOLARSHIP APPLICATION

NAME_____TELEPHONE_____

ADDRESS_____

DATE OF BIRTH_____ EMAIL ADDRESS_____

HIGH SCHOOL ATTENDED_____LOCATION_____

DATE OF GRADUATION_____GRADEPOINT AVERAGE*_____

A.C.T. COMPOSITE SCORE_____RANK IN CLASS_____NUMBER IN CLASS_____

HAVE YOU ATTENDED COLLEGE? _____NAME & LOCATION OF COLLEGE ATTENDED

_____

COLLEGE CREDITS_____ COLLEGE GRADE POINT AVERAGE*_____

STUDENT MUST SUBMIT BOTH THEIR HIGH SCHOOL AND COLLEGE TRANSCRIPTS

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 MATERIAL FEES_____

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 16, 2025****. NEITHER IMMEDIATE FAMILY MEMBERS NOR FELLOW STUDENTS ARE ACCEPTABLE. LIST YOUR THREE REFERENCES:

1._____ 2. _____ 3._____

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

FINANCIAL INFORMATION

APPLICANT INFORMATION:

APPLICANT'S MARITAL STATUS: ____ SINGLE ____ MARRIED

____ SEPARATED ____ DIVORCED _____WIDOW

NUMBER OF CHILDREN LIVING AT HOME_____

WILL THE APPLICANT BE EMPLOYED DURING SCHOOL?

If yes, where_____ Full Time_____ Part Time_____

EMPLOYMENT:

List below your work experience starting with your present or most recent place of employment:

1. Name and address of employer: _____

   Date employed: From: _____ To: _____

   Reason for leaving: _____

2. Name and address of employer: _____

   Date employed: From: _____ To: _____

   Reason for leaving: _____

APPLICANT'S SIGNATURE_____ DATE_____

CLOSING DATE FOR APPLICATION AND REFERENCE SHEETS IS **JUNE 16, 2025**

RETURN COMPLETED APPLICATION TO:

LABETTE HEALTH FOUNDATION
1902 S. US Highway 59
PARSONS, KS 67357

CONFIDENTIAL PROFESSIONAL REFERENCE

Please complete and return by June 16, 2025 to ensure that the applicant is considered for a scholarship.

Name of Scholarship Applicant_____

Your name _____Address_____

Relationship to applicant: Employer_____ Company Name_____
Teacher_____ Co-Worker_____ Other_____

Please check the items which accurately describe 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 applicant's need for financial assistance? _____
_____
_____
_____

How would you rate the applicant's general academic ability?

Outstanding _____ Average _____ Poor _____ No Opportunity to Observe _____

Other comments: _____
_____
_____
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