



## **PARTNERS SCHOLARSHIP**

*sponsored and funded by*

### **Partners of Osceola Medical Center**

#### **Purpose:**

The Partners has established a scholarship fund to provide financial assistance for an adult student beginning or continuing education in a medically related field of study.

#### **Awards:**

OMC Partners' Scholarship awards shall be limited to one as a high school senior, and one at the post-secondary student. One scholarship in the amount of \$1,000 will be awarded to each.

#### **Eligibility Criteria:**

1. Applicant must graduate in the top third of their class.
2. Applicant must be accepted at an accredited educational institution to pursue a health-related degree.
3. Applicants must be a resident of Osceola, WI or adjacent areas of Wisconsin or Minnesota.
4. Complete application must be received by April 1, 2010.

Please return completed application to your High School Guidance Counselor's Office.

Note: There shall be no discrimination based on race, creed, color or sex of scholarship candidate.



**PARTNERS OF OSCEOLA MEDICAL CENTER  
HIGH SCHOOL SCHOLARSHIP**

Deadline for receipt of application: April 1, 2010

All information will be treated confidentially. Please complete entire application.  
Incomplete applications will not be considered.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

Phone: \_\_\_\_\_ (Parent's) \_\_\_\_\_ (alternative number)

High School GPA: \_\_\_\_\_ High School Class Rank: \_\_\_\_\_ SAT/ACT Score \_\_\_\_\_

Major Field of Study: \_\_\_\_\_

Degree/Certificate Being Pursued: \_\_\_\_\_

Approximate Date of Post Secondary Graduation: \_\_\_\_\_

Have you been accepted by an accredited school, college or university?  Yes  No

Post Secondary School Attending: \_\_\_\_\_

School's Address: \_\_\_\_\_

\_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Counselor or Principal: \_\_\_\_\_ Date: \_\_\_\_\_



## **Applicant check list:**

All applications must include the following:

- Completed and signed application form
- High School transcripts
- Personal Statement: Please describe the health career you have chosen and what influenced your choice. Outline your goals and your plan to achieve them. Include information on extracurricular activities you have participated in and describe any awards you may have received. List the jobs you have held or volunteer work you have done and any influence they may have had on your health career choice. Please limit your personal statement to one type written page with minimum size 12 font.
- References: Attach reference letters to this application or ask references to be mailed directly to Osceola Medical Center by the deadline.
  - One letter of recommendation from a teacher or counselor familiar with your school performance.
  - One letter of recommendation from someone **not** related to you or affiliated with your school (e.g. supervisor, neighbor, friend, etc.)

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