



PARTNERS SCHOLARSHIP

sponsored and funded by

Partners of Osceola Medical Center

Purpose:

The Partners of Osceola Medical Center has established this scholarship to provide financial assistance for education beyond the high school level for a student entering an accredited school pursuing a medically related degree. This applies to a four-year program resulting in a Bachelor's degree, three-year college or vocational associate degree.

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 senior at Osceola High School and a resident of Osceola, WI or adjacent areas of Wisconsin or Minnesota.

Complete application must be received by April 1, 2011. Please return to your High School Guidance Counselor's Office or mail to:

Sue Gerlach
Osceola Medical Center
P.O. Box 218
Osceola, WI 54020

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, 2011

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.)

Osceola Medical Center
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Osceola, WI 54020
715-294-5789
susang@osceolamedicalcenter.com