



John Simenstad Family Scholarship Fund of Osceola Community Health Foundation, Inc.

PURPOSE:

Dr. John and Doris Simenstad established an endowment fund in 1987 to provide scholarships for Osceola area residents pursuing careers in health care. Dr. John served as an educator at Regions for over 10 years and was a strong advocate of education throughout his career. He and his wife Doris felt it was important to help others to achieve their academic goals. The funds are now managed by the Osceola Community Health Foundation, Inc.

ELIGIBILITY CRITERIA:

- Student that will have completed at least one year of post-secondary education in a health care field as of the summer of 2011.
- Resident in the Osceola, Wisconsin and adjacent areas of Wisconsin and Minnesota.
- Simenstad scholarships shall be awarded without regard to race, creed, color, religion, sex, national origin, age, disability or any other characteristic of any application that is protected by federal, state or local law.

DEADLINE FOR RECEIPT OF APPLICATION IS FRIDAY, APRIL 1, 2011.

Please return completed applications to:

Osceola Community Health Foundation, Inc.
Attn: Sue Gerlach
P.O. Box 218
Osceola, WI 54020

AWARDS will be paid jointly to the recipient and the recipient's college or university.



**OSCEOLA COMMUNITY HEALTH FOUNDATION, INC.
JOHN SIMENSTAD FAMILY SCHOLARSHIP FUND**

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: _____
(Home) (Alternative number)

Major Field of Study: _____

Degree/Certificate/Course Being Pursued: _____

Approximate Date of Post Secondary Graduation: _____

School Attended/Attending: _____

School's Address: _____

(City) (State) (Zip)

Name of High School Attended: _____ Graduation Date: _____

School's Address: _____

(City) (State) (Zip)

Post Secondary Cumulative GPA _____ (*Attach transcripts from college or technical school*)

Are you or is a member of your family an employee at Osceola Medical Center? Yes No

If 'Yes', name and relationship: _____

Signature of Applicant: _____ Date: _____

Applicant check list:

All applications must include the following:

- Completed and signed application form
- Post-secondary transcripts
- Personal Statement: Please describe the health career you have chosen, discuss your goals and what influenced your decisions. Outline your plan for achieving your goals. Describe why this scholarship is important to you. Please summarize information regarding the following:
 - Jobs you have held
 - Volunteer and/or community work you have done
 - Awards you have received
 - Extracurricular/outside activities you have participated in
- References: Please provide your references with a copy of the attached reference information request. Attach reference letters to this application or ask references to be mailed directly to Osceola Community Health Foundation by the deadline. Letters must be signed.
 - 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 Community Health Foundation, Inc.
Sue Gerlach, Director
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P. O. Box 218
Osceola, WI 54020
715-294-5789
susang@osceolamedicalcenter.com