

**RUSSELL MEDICAL CENTER
MEMORIAL SCHOLARSHIP
APPLICATION PROCESS**

Contact : Judy Wood (256)329-7152

Application process for the Scholarship is as follows:

1. Applicant must be accepted into an accredited nursing school and must submit letter of confirmation.
2. Application must be completed.
3. Applicant must submit a brief autobiography, including why he/she has chosen nursing as a career.
4. Two letters of reference must accompany the application (One professional and one personal).
5. Must submit a copy of study program with estimated cost analysis.
6. Applicant must submit transcripts from previous college studies and an overall GPA of 3.0 or greater is required.
7. Application must be completed and turned in to Administration by the following deadline:

The applicant must complete an interview with the Scholarship Committee which will be scheduled through the Administration Office of Russell Medical Center. The application process must be completed before an interview will be scheduled.

**RUSSELL MEDICAL CENTER
MEMORIAL SCHOLARSHIP
APPLICATION**

DATE: _____

NAME: _____ SOCIAL SECURITY # _____

ADDRESS: _____

PHONE: _____ MARITAL STATUS S M D W

MALE/FEMALE DATE OF BIRTH: _____ # OF DEPENDENTS _____

NURSING SCHOOL YOU PLAN TO ATTEND: _____

ANTICIPATED DATE OF GRADUATION: _____

ANTICIPATED DEGREE TO BE EARNED: _____

Employment History:

Employer	Dates of Employment	Reason for Leaving
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Educational Background:

Name of School	Date of Graduation	GPA
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any school and/or community activities in which you have been involved. Also, include any honors/awards you have received.

References:

Name	Occupation	Phone
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1. _____

2. _____

3. _____

Have you ever volunteered or been employed by Russell Medical Center? _____

If so, please give date(s) and what department(s) _____

I certify that all information listed on this application is correct. I understand and agree that Russell Medical Center may make inquiries to verify information on this application. In addition, any investigation into my character may be conducted and persons, including references listed in the application may be contacted for this purpose. I understand that any false or misleading information shall be sufficient cause for rejection or immediate termination of my scholarship. I hereby acknowledge that I have read and fully understand the foregoing statement.

Applicant's Signature

Date

For Hospital Use Only:

Approved: _____ Disapproved: _____ Date: _____

Date: _____
President

Date: _____
Director of Nursing

Comments: _____

