

**HAMILTON HOSPITAL AUXILIARY
SCHOLARSHIP APPLICATION FORM**

Name _____ Year graduated _____

Current address _____ City _____ Zip _____

Parent _____ Occupation _____

Number of children in the family _____

College choice _____ Major _____

College address _____ State _____ Zip _____

What are the yearly expenses of this college? _____

Have you applied? _____ If so, have you been accepted? _____

Have you applied for or are receiving any other financial aid? _____

If yes to the above question, what is the amount? _____

And, which of these is it: Grant _____ Loan _____ Scholarship _____

Program Type

Indicate the program in which you are enrolled or to which you have been accepted. **Please note education must be completed in 4 years.**

- | | |
|-------------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Clinical Lab Scientist/Medical Technologist | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Clinical Lab Technician/Medical Lab Technician | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Nursing (RN) | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Nursing (BSN) | <input type="checkbox"/> Radiation Therapist |
| <input type="checkbox"/> Nursing (Masters-MSN) | <input type="checkbox"/> Physical Therapist Assistant |
| <input type="checkbox"/> Nurse Practitioner (NP) | <input type="checkbox"/> Respiratory Therapist |
| <input type="checkbox"/> Certified Nurse Anesthetist (CRNA) | <input type="checkbox"/> Social Worker (LISW) |
| <input type="checkbox"/> Clinical Nurse Specialist (CNS) | <input type="checkbox"/> Surgery Technician |
| <input type="checkbox"/> Nurse Administrator | <input type="checkbox"/> Ultrasound Technologist |

Two (2) written references **must accompany** this application by a non-relative:

1. _____

2. _____

If recipient is unable to attend school, the award would revert back to the Auxiliary to be given to an alternate. You will notify as per #8 on the attached sheet.

I hereby promise that the above information is true and not falsified to the best of my knowledge.

Signature _____

Use reverse side if more room is needed to provide information. Reverse yes ___ no ___

Please send completed application by April 15 to: Hamilton Hospital,
800 Ohio Street, Webster City, IA 50595 Attn: Mary Ann Erickson