LINTON REGIONAL MEDICAL CENTER FOUNDATION
SCHOLARSHIP PROGRAM APPLICATION FORM
UNIVERSITY LEVEL
Application Postmark Deadline July 15

Only original applications are acceptable. Copies will be disqualified. Applications are evaluated on the information supplied. Therefore, it is important to answer EVERY question.

Applicant Data

Full Name:	E-mail Address:	
Permanent Street Address:		
City:	State:	Zip:
Home Phone: ( )	Message Phone: ( )	
Highest Level of Education ☐ High School Diploma ☐ Associate Degree ☐ Bachelor's Degree ☐ GED ☐ Other _____		

Educational Plans (Do not abbreviate school names. Accredited schools only.)

School Name:	Phone: ( )	
Address:	City:	State:

Type of School (Check one): ☐ Two-Year Junior or Community College ☐ Hospital School ☐ Four-Year College or University ☐ Vocational/Technical School ☐ Accredited State Health Care Board Program

Type of Program:

☐ Dietetics ☐ Medical Records / Transcription ☐ Medical Technology ☐ Nursing – RN
☐ Pharmacy ☐ Occupational Therapy ☐ Physical Therapy ☐ Nursing – LPN
☐ Radiology ☐ Respiratory Therapy ☐ Speech Pathology ☐ Other

Type of Certificate / Degree ☐ AA / AB ☐ BA / BS ☐ Diploma ☐ Other _____

Enrollment: ☐ Full-time ☐ Part-time Number of Credit Hours _____

Expected Graduation Date: (Month / Year) _____

Work Experience (if applicable)

Describe your work experience during the past ten years. Indicate dates of employment in each job and approximate number of hours worked each week. Attach a separate sheet of paper if necessary.

Company Name and Address	Position	Worked From – To Month and Year	Hours per Week

References

Please provide three letters of reference.

Goals and Aspirations

1. List any community service/volunteer work you have done.

_____

_____

2. List any honors/awards you have received or any extracurricular activities you have been involved in.

_____

_____

3. List any leadership roles or organizations you have been involved in.

_____

_____

Essay

Every applicant must submit a one-page essay on the following. Please attach a separate sheet.

1. Who or what event inspired you to pursue a career in the medical profession?
2. Where do you feel this field will take you and what service do you see yourself providing to society or the community?

Transcript

Every applicant must submit a complete official transcript of college grades. On-line transcripts are not acceptable. Failure to provide transcript will disqualify applicant.

Acceptance Letter

Every applicant must submit a copy of the official acceptance letter received from the University/College they will be attending.

Certification

I certify that the information provided is complete and accurate to the best of my knowledge. Falsification of information will result in the scholarship becoming immediately due and payable to Linton Regional Medical Center Foundation. This application becomes the property of Linton Regional Medical Center Foundation.

Applicant's Signature: _____ Date: _____

The Linton Regional Medical Center Foundation awards scholarships without regard to race, religion, creed, age, sex or national origin. The Linton Regional Medical Center Foundation is an equal opportunity and grantor.

Application and transcript must be mailed to: Scholarship Program, Linton Regional Medical Center Foundation, PO Box 850, Linton ND 58552 by the July 15 postmark deadline.