# GUIDELINES FOR THE LINTON REGIONAL MEDICAL CENTER FOUNDATION SCHOLARSHIP PROGRAM UNIVERSITY LEVEL

#### **Eligibility**

Applicants eligible for this scholarship must:

- Enrolled in and accepted into a medical course of study leading to a certificate, diploma, license, associate or bachelor's degree at an accredited college or university, or a vocationaltechnical school; and
- 2. Be a high school graduate of Hazelton, ND; Linton, ND; Strasburg, ND; Herreid, SD; or a child or spouse of an employee at the Linton Regional Medical Center or one of its clinics.

#### **Awards**

The award will consist of scholarship funds worth \$2,000.00 and can be used for tuition, required fees, or books.

#### **Payment of Awards**

The award will be made payable to the university and mailed directly to the university to be deposited in the recipient's financial account.

#### **Recipient Requirements**

The recipients will be required to submit a picture of themselves holding their certificate to: <a href="mailto:foundation@lintonhospital.org">foundation@lintonhospital.org</a>. These pictures will be used for the LRMCF Giving Hearts Day campaign to raise funds for future scholarships.

#### **Required Forms**

- 1. Scholarship application form
- 2. Unofficial transcripts verifying GPA
- 3. Three references from non-relatives
- 4. Essay
- 5. Letter of acceptance from attending University/College

#### Questions

Questions regarding the LRMCF scholarship program may be directed to the following people or mailed to the address below:

Jessica Jacob or Denise van Leeuwan 701-254-3175 701-254-3133

#### **Return the required forms by JULY 15 to:**

Scholarship Selection Committee Linton Regional Medical Center Foundation PO Box 850 Linton, ND 58552

## 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:			Zip:		
Home Phone: ( )		Message Phone: ( )			
Highest Level of Education ☐ High Scl	hool Diploma	ate Degree	nelor's Degree		
$\Box$ GED		□ Other			
Educational Plans (Do not abbrevia	te school names. Acc	redited schools o	only.)		
School Name:		Phone: ( )			
Address:		State:			
Type of School (Check one):  □ Four-Year College or University	☐ Two-Year Junior or Comm☐ Vocational/Technical Scho			tal School ard Program	
Type of Program:  Dietetics Medical Records / Transcription Pharmacy Occupational Therapy Radiology Respiratory Therapy  Type of Certificate / Degree AA / AB BA / BS		Medical Technology		ng – LPN	
Enrollment:     Full-time   Respected Graduation Date: (Month / Yes)	Part-time Number of ear)			-	
Work Experience (if applicable)					
Describe your work experience during the approximate number of hours worked each	-		•	o and	
Company Name and Address Positi			Worked From – To  Month and Year  V		

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			
<ul> <li>Every applicant must submit a one-page essay on the following. Please attach a separate sheet.</li> <li>1. Who or what event inspired you to pursue a career in the medical profession?</li> <li>2. Where do you feel this field will take you and what service do you see yourself providing to society or the community?</li> </ul>			
Transcript			
Every applicant must submit a complete unofficial 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.