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

## Eligibility

Applicants eligible for this scholarship must:

1. Be enrolled in a medical course of study leading to a certificate, diploma, license, associate or bachelor's degree at an accredited college or university, or a vocational-technical 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 that can be used for tuition, required fees, or books.

## Payment of Awards

Checks 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: foundation@lintonhospital.org. 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 into a medical course of study 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 1 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 1**

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 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, into a medical course of study, 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 1 postmark deadline.