SCHOLARSHIP APPLICATION

THURNALD HINSON MEMORIAL SCHOLARSHIP

PROGRAM DESCRIPTION

The purpose of the Thurnald Hinson Memorial Scholarship is to increase the number of appropriately trained healthcare professionals providing direct patient care in Trinity County. One thousand dollars ($1000) scholarships are awarded to persons entering or continuing their education in such fields as nursing, occupational therapy, radiology, laboratory, pharmacy and respiratory care.

ELIGIBILITY

- The applicant must agree to practice in direct patient care for at least one year in a paid position in Trinity County, California, if such a position is available. This includes but is not limited to:

- Phlebotomist
- Radiologist
- Registered Dietician
- EMT
- Family Nurse Practitioner
- Physician's Assistant
- Laboratory Technician
- CNA, LVN, or RN

- The applicant must provide proof of enrollment or acceptance by an accredited or approved healthcare education program.
- The applicant must be a full time Trinity County resident, and have resided in Trinity County for at least the past twelve months.
- The applicant must provide two letters of recommendation from former teachers/employers or other community representatives.
- The applicant must be available for a personal interview.

CRITERIA FOR AWARD SELECTION

Information about the applicant's qualifications will be obtained from:

- The application form.
- Letters of recommendation from former teachers/employers or other community representatives.

The criteria to be used in determining the award of each scholarship is as follows:

- The applicant's work/volunteer experience (both related and unrelated to healthcare).
- The community involvement of the applicant.
- The applicant's career goals (what are your professional goals and plans for the next five years).
- Prior academic performance and potential for future academic success.

THURNALD HINSON MEMORIAL SCHOLARSHIP APPLICATION

TO BE COMPLETED BY APPLICANT
(Please type or print with black or blue ink)

SECTION ONE – PERSONAL/PROFESSIONAL DATA

NAME: _____

MAILING ADDRESS: _____
P.O. Box or Street City Zip Code

PERMANENT ADDRESS: _____
P.O. Box or Street City Zip Code

PHONE TO BE REACHED WORK: _____ **HOME:** _____ **CELL:** _____

ARE YOU CERTIFIED/LICENSED/REGISTERED IN ANY SPECIALTY? ____YES ____NO

IF YES, SPECIALITY: _____**NUMBER:**_____

NAME OF EMPLOYER: _____

ADDRESS: _____
P.O. Box or Street City Zip Code

PHONE: _____ **SUPERVISOR:** _____

SECTION TWO – EDUCATION

____I AM CURRENTLY ENROLLED IN AN ACCREDITED HEALTHCARE EDUCATION TRAINING PROGRAM

___I HAVE BEEN ACCEPTED TO AN ACCREDITED HEALTHCARE EDUCATION TRAINING PROGRAM

NAME OF SCHOOL: _____

ADDRESS: _____
P.O. Box or Street address

_____
City State ZIP code

PHONE: _____

PROGRAM DIRECTOR: _____

PROGRAM ENTRY DATE: _____ **EXPECTED GRADUATION DATE:** _____

WILL YOU ATTEND: ____FULL TIME ___PART TIME

SECTION THREE – SHORT QUESTIONS

ON A SEPARATE SHEET OF PAPER, PLEASE ANSWER AND COMPLETE THE FOLLOWING:

1. **PLEASE DESCRIBE YOUR WORK EXPERIENCE. TELL US ABOUT YOUR WORK AND HOW LONG YOU HAVE BEEN EMPLOYED.**

2. **PLEASE DESCRIBE ANY COMMUNITY/VOLUNTEER ACTIVITIES OR EXTRACURRICULAR ACTIVITIES IN WHICH YOU HAVE BEEN OR ARE CURRENTLY INVOLVED IN.**

3. **PLEASE DESCRIBE YOU CAREER GOALS:**

    A. What kind of work would you like to do immediately after graduation?
    B. What kind of work do you think you will be doing in five years?
    C. What is your vision of your professional future?

4. **PLEASE ATTACH TWO LETTERS OF RECOMMENDATION FROM FORMER TEACHERS/EMPLOYERS OR OTHER COMMUNITY REPRESENTATIVES.**

SIGNATURE: _____ DATE: _____

I hereby certify that the information contained in this application is true and correct to the best of my knowledge and agree to have any of the statements checked by MCHF unless I have indicated to the contrary. I authorize the references listed above, as well as all other individuals whom MCHF contacts, to provide MCHF any and all information concerning my previous employment and any other pertinent information that they may have. Further, I release all parties and persons from any and all liability for any damages that may result from furnishing such information to MCHF as well as from any use or disclosure of such information by MCHF or any of its agents, employees, or representatives. I understand that any misrepresentation, falsification, or material omission of information on this application may result in my failure to receive the scholarship; or, if I am awarded the scholarship, I may be required to return all scholarship funds I have received.

CHECK LIST:

- ☐ DESCRIPTION OF WORK EXPERIENCE
- ☐ TWO LETTERS OF RECOMMENDATION
- ☐ ARE ALL SECTIONS OF THE APPLICATION COMPLETED?
- ☐ PROOF OF ENROLLMENT OR ACCEPTANCE IN AN ACCREDITED OR APPROVED HEALTHCARE EDUCATION PROGRAM

PLEASE SEND COMPLETED APPLICATION TO:

Thurnald Hinson Memorial Scholarship
c/o Mountain Communities Healthcare Foundation
P.O. Box 3051
Weaverville, CA 96093