Carolyn S. (Betty) McCormick Scholarship Application 2014

Sponsored by the

Bryan W. Whitfield Memorial Hospital

Auxiliary

<u>Applications must be entirely complete</u>. Upon completion, the application is to be RECEIVED by 3:00 p.m. on Feb. 19, 2014 in the office of the Director of Volunteer Services. Incomplete and/or late applications will not be considered for a scholarship. The Auxiliary is not responsible for lost or late mail.

BRYAN W. WHITFIELD MEMORIAL HOSPITAL AUXILIARY
CAROLYN S. (BETTY) MCCORMICK SCHOLARSHIP PROGRAM

The Bryan W. Whitfield Memorial Hospital Auxiliary wishes to encourage the active pursuit of education, particularly in healthcare related fields. To this end, the Auxiliary has developed the Carolyn S. (Betty) McCormick Scholarship Program to support and encourage the acquisition of education in the field of healthcare and to meet future human resources needs of the Tombigbee Healthcare Authority.

ELIGIBILITY

The Auxiliary may award up to $1,500 annually in financial assistance to children or grandchildren of employees of the Tombigbee Healthcare Authority who wish to pursue education in the field of healthcare, without regard to race, color, creed, or national origin. Children and grandchildren of THA employees who apply for this scholarship, may not apply for any other Bryan Whitfield Memorial Hospital Auxiliary sponsored scholarship.

Any individual who is a graduating high school senior or above may apply for the Carolyn S. (Betty) McCormick Scholarship from the Auxiliary as long as their chosen field of study is within the healthcare professions. The applicant must provide proof of relationship to a THA employee. The applicant must possess a high school education or equivalent GED or other qualification relevant to the field of study applicable. The applicant must provide proof of residency in either of the following counties: Marengo, Sumter, Hale, Choctaw, Perry, Greene, and Clarke.

The Auxiliary reserves the right to deny, limit, or otherwise reject the application of any individual who, in the opinion of the Auxiliary Executive Committee, has failed to demonstrate acceptable academic performance in previous educational endeavors and meet all criteria, standards, and expectations relevant to the selection process. The Auxiliary reserves the right to require immediate complete refund of disbursed funds if, after receiving the scholarship, the applicant drops out of school or changes their field of study to a non-healthcare related field.

SELECTION OF SCHOOLS

The BWWMH Auxiliary recognizes the right of individuals to select the school that he/she wishes to attend. However, the BWWMH Auxiliary reserves the right to deny, limit, or otherwise reject applicants who wish to attend schools which are not accredited or which, in the experience of the Tombigbee Healthcare Authority, have been found to have high rates of failure on licensure examinations or a high rate of failure among students.

DISBURSEMENT OF FUNDS

The disbursement of funds for scholarship students shall be limited to tuition, books and lab fees. These shall be paid directly to the institution in which they are enrolled pursuant to receipt of an official itemized billing from that institution.

APPLICATION PROCESS

Applications for scholarships may be obtained from the Director of Volunteer Services of the Tombigbee Healthcare Authority, Monday through Wednesday, from 8:00 a.m. to 3:00 p.m. Applications ***MUST*** include the following:

- Application form
- A letter of acceptance from the accredited school you plan to attend
- Transcripts of grades from high school, or in the event the applicant has attended college, college transcripts. All transcripts must be official documents.
- A copy of your ACT scores.
- Three letters of reference from individuals other than relatives. Employers, teachers, pastors, etc., are considered acceptable references. These must be **forwarded directly from the reference to our office**. DO NOT include these with your application.
- A resume
- Proof of residence
- A brief paragraph regarding career goals, as outlined on the application
- Proof of Household Income
- Current reproducible photograph, as well as current photo identification. Photos become the property of BWWMH Auxiliary but will be returned if a self-addressed, stamped envelope is included with application.
- Proof of relationship to THA Employee (birth certificate)

Applications must be entirely complete. Upon completion, the application is to be RECEIVED by 3:00 p.m. on Feb. 19, 2014 in the office of the Director of Volunteer Services. Incomplete and/or late applications will not be considered for a scholarship. The Auxiliary is not responsible for lost or late mail.

The decision of the BWWMH Auxiliary Scholarship Committee in regard to awarding of a scholarship shall be final in all cases. The applicant to whom a scholarship is awarded will be notified by mail by the BWWMH Auxiliary Executive Committee and will be awarded their scholarship in a ceremony during National Volunteer Week in April. The Auxiliary reserves the right to reject any or all applications. All applications and supporting documentation become the property of the BWWMH Auxiliary and will not be returned.

SCHOLARSHIP RECIPIENTS WILL BE ANNOUNCED ON OUR WEBSITE, www.bwwmh.com, BY APRIL 1, 2014.

BRYAN W. WHITFIELD MEMORIAL HOSPITAL AUXILIARY
CAROLYN S. (BETTY) MCCORMICK SCHOLARSHIP
PROGRAM APPLICATION

(PLEASE PRINT AND FILL IN ALL BLANKS)

I hereby apply to the Bryan W. Whitfield Memorial Hospital Auxiliary for a Carolyn S. (Betty) McCormick Scholarship to assist with the payment of my educational expenses while pursuing studies to complete requirements to become a (enter what profession you wish to pursue in this blank)_____.

PERSONAL DATA:

Name: _____

Permanent Address: _____

_____

Phone: _____ Email Address: _____

Name of parent/grandparent who is an employee of the Tombigbee Healthcare Authority: _____

Department in which the above is employed: _____

Relationship to the above (check one): _____ child _____ grandchild

Father's Name: _____ Mother's Name: _____
(or Legal Guardian) (or Legal Guardian)

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Do you live with your parents? _____ Are you a U.S. Citizen? _____

Date of Birth: _____ Age: _____ Place of Birth: _____

Are you a high school graduate? _____ Year graduated: _____ Class Standing: _____

High School Attended: _____

Address: _____

Are you a college graduate? _____ Year graduated: _____ Class Standing: _____

College Attended: _____ Degree: _____ GPA: _____

Address: _____

How many residents of your household will be attending college next year? _____

List three (3) references (do not list relatives):

	Name	Address	Phone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

ACADEMIC DATA:

Name of Professional School: _____

Address: _____

_____

Phone: _____

Have you been accepted? _____

MISCELLANEOUS **(PLEASE NOTE, WHETHER YOU HAVE APPLIED PREVIOUSLY OR NOT, ALL OF THE FOLLOWING INFORMATION IS *REQUIRED* IN ORDER FOR YOUR APPLICATION TO BE CONSIDERED COMPLETE. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.):**

Attach a letter of acceptance from the accredited school you plan to attend.

- Attach a resume.
- In a brief paragraph (100-150 words) describe why you have chosen healthcare as a career, and why you feel you should be considered for the Carolyn S. (Betty) McCormick Scholarship.
- Attach a certified transcript of high school, or in the event the applicant has attended college, college transcripts, diploma(s), and M-CAT or other applicable scores.
- Attach a copy of your ACT scores.
- Attach proof of residence.
- Attach a current reproducible photograph, as well as current photo identification. Photos become the property of BWWMH but will be returned if a self-addressed, stamped envelope is included with your application.
- Attach proof of household income.
- Attach proof of relationship to the THA employee mentioned above.
- Mail completed application and supporting documentation, as well as have 3 letters of reference **forwarded directly from the reference**:

  Director of Volunteer Services
  Bryan W. Whitfield Memorial Hospital Auxiliary
  P.O. Box 890
  Demopolis, AL 36732

The above items have been completed and are true and correct.

Signature: _____ Date: _____

Address: _____

_____

Tombigbee
Healthcare Authority