

PHYSICIANS' CHARITABLE FOUNDATION 2014 SCHOLARSHIP APPLICATION

DEADLINE FOR SUBMISSION: MARCH 15, 2014

PLEASE RETURN FORM TO:

PHYSICIANS' CHARITABLE FOUNDATION
C/O MEDICAL STAFF OFFICE
MERCY HOSPITAL ANDERSON
7500 STATE ROAD
CINCINNATI, OHIO 45255

Requirements to Complete this Application:

1. Completed application form including Personal Mission Statement
2. Personal letter of recommendation
3. Letter of reference to support your community service interests and/or achievements
4. High School Counselor or Principal's signature on application
5. Parental financial need endorsement and testimonial
6. Transcript of high school grades including SAT or ACT scores

1. Personal Information

Name: _____

Address: _____

Phone: _____ SSN#: _____ e-mail: _____

High School: _____

High School Guidance Counselor: _____

High School Activities (Student Council/Government, Teams, Clubs, Honors, etc.)

(attach additional sheet if necessary):

Community Interests / Achievements / Volunteer Work or Paid Employment (attach additional sheet if necessary):

Health-related Science Career Goals or Interests:

Personal Mission Statement – Vision – Goals – Make a Difference

Please accompany this application with a personal essay limited to 250 words featuring something about yourself and your interests, what you may have gained/given in your community service experiences and how this scholarship will help you to achieve future health care career goals, and any additional pertinent information.

2. Personal Reference (letters should be submitted separately)

Name: _____

Address: _____

Phone: _____ e-mail: _____

3. Community Service and/or Achievement Reference (letter should be submitted separately)

Name: _____

Address: _____

Phone: _____ e-mail: _____

4. Guidance Counselor or Principal’s Endorsement

I support the application of _____ for the Physicians’ Charitable Foundation Scholarship and certify that he/she has attained a grade point average of _____ for grades 10, 11, and 12 for 3-year high school, or grades 9, 10, 11, 12 for a 4-year high school, through 12/31/13.

Signature: _____

Printed Name: _____

Phone: _____ e-mail: _____

5. Financial Statement and Affidavit

I / We understand as the parent(s) / guardians of _____ that the Physicians' Charitable Foundation Scholarship is awarded, in part, based on financial need and accordingly attest in good conscience that our son / daughter is financially deserving of consideration for this scholarship award. (Parents may attach a separate confidential, optional, description of special factors delineating need for financial assistance for their child if desired. This statement could summarize the family's obligations and resources. This statement can be mailed, separately, if desired to the Physicians' Charitable Foundation, Medical Staff Office, Mercy Hospital Anderson, 7500 State Road, Cincinnati, OH 45255.)

By signing this form I / we attest that all information in this application and all attachments are a true and accurate record.

Parental

Signature(s): _____ Date: _____

Printed

Name(s): _____

Home Phone: _____ e-mail: _____

Applicant's Signature: _____ Date: _____

Printed Name: _____

Affiliation with Mercy Anderson

Special Consideration is given to employees and volunteers of Mercy Hospital Anderson and their dependents. If you or a relative are an employee or volunteer, please give the name and position of that individual.

Name: _____

Position: _____