



## Genesis Medical Center, Aledo Auxiliary

### Scholarship Application

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Birthdate \_\_\_\_\_ Phone \_\_\_\_\_

What medical field do you plan to enter? \_\_\_\_\_

What are your professional goals? \_\_\_\_\_

Give a short profile of yourself and why you chose this career (use additional sheet if necessary) \_\_\_\_\_

Have you been involved as a volunteer, employee, or student of this profession? \_\_\_\_\_

Please list your highest level of high school or college, including the names of these schools and any graduation dates. \_\_\_\_\_

What school do you plan to attend? \_\_\_\_\_

List estimated expenses per academic year.

Tuition \_\_\_\_\_ Room & Board \_\_\_\_\_ Books \_\_\_\_\_

List estimated resources while attending school.

Savings \_\_\_\_\_ Loans \_\_\_\_\_ Employment \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

#### Mail application to:

**Genesis Medical Center, Aledo Auxiliary, 409 NW 9<sup>th</sup> Ave., Aledo, IL 61231.**

**Please note: Application must be returned by May 1<sup>st</sup>. It will not be eligible if postmarked after this date.**