

**GENESIS MEDICAL CENTER, ALEDO AUXILIARY
SCHOLARSHIP APPLICATION
PLEASE WRITE CLEARLY**

NAME _____

ADDRESS _____ 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 _____

HAVE YOU BEEN INVOLVED AS A VOLUNTEER, EMPLOYEE, OR STUDENT OF THIS PROFESSION? _____

WHAT HIGH SCHOOL AND COLLEGES HAVE YOU ATTENDED AND/OR GRADUATED FROM? _____

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WHAT SCHOOL DO YOU PLAN TO ATTEND? _____

LIST APPROXIMATE EXPENSES PER ACADEMIC YEAR:
\$ _____ TUITION \$ _____ ROOM & BOARD \$ _____ BOOKS

LIST APPROXIMATE RESOURCES PER ACADEMIC YEAR:
\$ _____ SAVINGS \$ _____ LOANS \$ _____ OTHER

EMPLOYMENT WHILE ATTENDING SCHOOL: \$ _____

SIGNATURE _____

**PLEASE RETURN THIS APPLICATION BY APRIL 15TH. MAIL TO:
GENESIS MEDICAL CENTER, ALEDO AUXILIARY
409 NW 9TH AVE., ALEDO, IL. 61231**