

MEMORIAL HOSPITAL FOUNDATION

NURSING SCHOLARSHIP

TYPE OR PRINT ALL INFORMATION

APPLICATION POSTMARK DEADLINE IS: **April 15th**

Completeness and neatness ensure your application will be reviewed properly.

**APPLICANT
DATA**

_____	_____	_____
Last Name	First Name	Middle Initial

Permanent home mailing address		
_____	_____	_____
City	State	Zip Code
_____	_____	
Phone	E-mail Address	
_____	_____	
Nursing Program/School	Anticipated graduation month and year	

If space provided in any section is inadequate, you may continue on additional sheets of paper using the same format. DO NOT repeat information already reported on the application form. Your name, address and name of this scholarship program should be included on all attachments.

The student is responsible for submitting all materials to MHHCC Human Resources by identified timeframes. Incomplete applications will not be evaluated. This application becomes complete and valid only when MHHCC Resources has received all of the following materials:

**APPLICATION
CHECKLIST**

- Student Application (this packet must be submitted on line or emailed).
Emailed to: URRNH@QJUDP at _____ a

Mailed to:

Human Resources - Memorial Hospital Foundation Nursing Scholarship
800 w 9th St
Jasper, IN 47546
Attention: Brooke Ingram

- Current official transcript
(can be mailed or electronically requested).
- Student Clinical Performance Evaluation Form
(Last page of application, form must be signed by student and sent to instructor).

WORK EXPERIENCE

List your work experience during the past four years. Indicate dates of employment for each job and approximate number of hours worked each week.

Present or Last Employer _____ Phone (including area code) _____

Address _____ City _____ State _____ Zip _____

Name While Employed _____ Job Title _____ Start Date _____ End Date _____

Supervisor's Name _____

Summary of Duties _____

Reason for Leaving _____

Present or Last Employer _____ Phone (including area code) _____

Address _____ City _____ State _____ Zip _____

Name While Employed _____ Job Title _____ Start Date _____ End Date _____

Supervisor's Name _____

Summary of Duties _____

Reason for Leaving _____

ACTIVITIES, AWARDS AND HONORS

List all school activities in which you have participated during the past four years (e.g. student government, music, etc.) List all community activities in which you have participated without pay during the past four years (e.g. Boy/Girl Scouts, hospital volunteer). Note all special awards, honors, and offices held. Indicate whether high school or college activities.

Activity	Number of Years Participation	Special Awards, Honors	Offices Held

GOALS AND ASPIRATIONS

Provide a statement or summary of your plans as they relate to your educational and career objectives and long-term goals. (Please attach a separate page if additional space is needed.)

DISTINGUISHING QUALITIES

Please describe any characteristics about yourself that you feel distinguish you from your peers. Please do not repeat information that is included elsewhere in this application.

TRANSCRIPT INFORMATION

An official transcript of grades must be sent with this application.

Mailed Sent Online

Must be official, can be mailed or sent online by electronically requesting an eTranscript.

Mailed Transcripts should be addressed to:

Human Resources - Memorial Hospital Foundation Nursing Scholarship
Attn: Brooke Ingram
800 W 9th St
Jasper, IN 47546

Online transcripts must be ordered to be sent to Brooke Ingram at bingram@mhcc.org.

BACKGROUND

Have you ever been convicted of a crime, excluding minor traffic violations?
If yes, please list the conviction date, court, location and type of the offense.

Yes No

PLEASE READ AND SIGN

I voluntarily authorize Memorial Hospital and Health Care Center to make a thorough pre-employment investigation, including a limited criminal history background check for the purpose of qualifying for a Memorial Hospital Foundation Nursing Scholarship. I understand that I have the right to obtain a copy of that report at my own expense and to challenge any information that I believe to be inaccurate. I hereby authorize former and present employers and others to provide or verify any information they have regarding my employment or me and release them from any liability for furnishing such information to Memorial Hospital and Health Care Center. I understand that scholarship qualification and employment is contingent on satisfactory outcomes of reference and background checks. The information in this document that I have provided is true and complete, and I have met the eligibility requirements of the program as described. False statements on this scholarship application and employment-related documents shall be considered sufficient cause for denial of scholarship qualification. Falsification of information may result in termination of any scholarship granted upon discovery of such falsification. If I receive a Memorial Hospital Foundation Nursing Scholarship and an offer for employment, I agree to have a medical evaluation and understand that any subsequent employment is contingent upon passing that evaluation. As an employee, I agree to take such future medical evaluation as may be lawfully required by MHHCC. If I am employed, I understand that I may be required to work weekends, holidays and overtime and hereby agree to do so. I agree to accept a temporary shift or unit change whenever emergency conditions warrant. If employed, I agree to abide by the policies, procedures and rules of MHHCC and the department to which I am assigned. I further agree to protect the confidentiality and privacy of any information regarding MHHCC and its patients. I acknowledge that decisions of MHHCC Hospital and its Selection Committee are final. This application and its attachments become the property of MHHCC. (It is recommended that you keep a copy for your files.)

Applicant's Signature for Memorial Hospital Foundation Nursing Scholarship Program and Employment Application Records	Date
--	------

STUDENT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize you and your institution to provide the information requested and release you and your institution from any liability resulting therefrom. All information provided to Memorial Hospital and Health Care Center will be held in confidence and used for the specific purpose of the Nurse Intern Application process.

Student Name (please print) _____

Student Signature _____ Date _____

STUDENT PERFORMANCE EVALUATION

(to be completed by nursing faculty)

School of Nursing _____ Instructor _____

Please use a scale of 1 to 5 (1 = Unsatisfactory, 5 = Excellent) to rate the student on the following performance criteria:

- | | |
|--|---|
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Organizational Skills |
| <input type="checkbox"/> Initiative | <input type="checkbox"/> Integrity |
| <input type="checkbox"/> Quality of Work | <input type="checkbox"/> Cooperation |
| <input type="checkbox"/> Attitude | <input type="checkbox"/> Relationship with Others |
| <input type="checkbox"/> Team Work | <input type="checkbox"/> Communication Skills |

Comments/Strengths/Areas for Improvement:

I would recommend this student for the Memorial Hospital Foundation Nursing Scholarship:

Yes No

If no, why not: _____

Faculty Signature _____

Date _____

Printed Name _____

***Submit this release of information and evaluation form to:**

Human Resources, Attn. Brooke Ingram
Memorial Hospital and Health Care Center
800 W Ninth Street
Jasper, IN 47546

OR via email to: bingram@mhcc.org

If you have any questions, please contact Human Resources at 812-996-6326.