Citizens Health / Citizens Foundation
Health Care Scholarship Application

Scholarships applied for (circle all that apply or check the box):

❑ I would like to apply for ALL available scholarships

Citizens Foundation

***Board of Regents (Nursing)**

*requires an employment contract, call for more details

Date_____

Name_____
Last First Middle

Present Address_____
Street City State Zip

Telephone Number (home)_____(cell)_____

Permanent Address_____
Street City State Zip

Email Address_____

School/Certification program I plan to attend_____

Anticipated school cost per year_____
Have you been accepted Yes ❑ No ❑
If yes, the date to begin program_____
Anticipated date of graduation (month/year)_____

Type of degree:
- ❑ Certificate (Specify type)_____
- ❑ Associate (Specify type)_____
- ❑ Baccalaureate (Specify type)_____
- ❑ Other (Specify)_____

Education: What high school, junior or community college, or university have you attended? Enter last school attended first.

School City/State Dates Attended Graduation Date

_____

_____

_____

Previous employment record: (Enter last job first)

Employer	Dates	Position	Reason for Leaving

What are your short-term goals? (2 to 3 years)

_____

_____

_____

_____

What are your long-term goals? (5 to 10 years)

_____

_____

_____

_____

AGREEMENT: If I am awarded a Citizens Medical Center, Inc. Health Care Scholarship, it is my intention to complete my course of study. I agree to inform the Scholarship Committee immediately upon any decision I may make concerning any change in my plan of study. I agree that this application and all credentials submitted by me or others on my behalf will remain the confidential property of the Citizens Medical Center, Inc. Scholarship Committee.

_____

Signature of Applicant Date

I hereby certify that all answers given by me on this application are true and correctly answered. I authorize the Citizens Medical Center, Inc. Scholarship Committee to check with my former employers, and other sources deemed necessary to verify the facts and information furnished with regard to my character and qualifications. I hereby release any such employer or person from any and all liability of whichever nature due to furnishing such information. I understand that any false or intentionally misleading statements, or omissions of important information, shall be sufficient grounds for disqualification in this scholarship process and will affect any future applications I should submit.

_____

Signature of Applicant Date

How did you become aware of our program?_____

What county in Kansas do you live? _____

Are you employed by Citizens Medical Center, Inc. Yes ❑ No ❑

Do you have friends or relatives employed by Citizens Medical Center, Inc?

Yes ❑ No ❑ If yes, who?_____

In order for your application to be considered you must submit the following:

- This completed application form
- A copy of most recent high school or college transcript
- Three letters of reference (preferably one from a current or recent employer and one from a current or recent instructor including their contact information.) Topics to include example of applicant's: character, academic ability, ability to work with others & probability of success in chosen program.
- An essay addressing:
    - Your reasons for selecting your course of study in the health care field
    - Your strengths and capacity to succeed
    - Your commitment to rural health care
    - Your commitment to community
    - Why you believe you should be considered for this award
    - What specifically you will use this scholarship money for

All applications **must be received** by April 1st at 3:00PM of each year. There will be no exceptions made to this deadline. Send completed application to:

Citizens Foundation
CMCI Health Care Scholarship Program
100 East College Drive
Colby, KS 67701

For any questions you may have, please contact us at (785) 460-1214.