Lake County Medical Alliance

Debbie McNaughton
Scholarship Chairperson
11520 Gate Post Lane
Chardon, OH 44024

UNDERGRADUATE HEALTH CAREERS SCHOLARSHIP CRITERIA

ELIGIBILITY

1. Must be a *resident of Lake County* – gender and age are not factors.
2. Must have already been accepted by an accredited college or university *for the study of a health-related or allied health field on the undergraduate level*. (**SOME FIELDS ARE EXCLUDED, SUCH AS PRE-MED, PSYCHOLOGY, DENTAL HEALTH, AND VETERINARY HEALTH.)**
3. Students must be enrolled and attending school full-time within six months of the granting of the scholarship.
4. We encourage students with financial need to attend Ohio state schools or financially similar institutions.
5. Should a recipient find he/she is unable to use this scholarship during the current year, he/she must forfeit all right to it.
6. ***Application must be fully completed with all attachments to be considered.*** This includes parent signature(s) unless the student is financially independent of all help from parents. Applications that are incomplete or late will be declared ineligible.

CRITERIA FOR SELECTION

1. Acceptance into an accredited college/university department for health-related studies.
2. Financial need.
3. Academic success: A minimum "B" (3.0 or higher) GPA in most recently attended school. *This average must be maintained to renew the scholarship.*
4. Current SIGNED recommendation from school personnel, preferably a classroom instructor; if applicant is out of school longer than one year, recommendation of an employer or guidance counselor.

REQUIRED ATTACHMENTS

1. Transcript of grades, including most current class standing; and copy of current first semester grade report.
2. Current SIGNED letter of recommendation (from number 4 above under CRITERIA FOR SELECTION above) discussing applicant's character and abilities.
3. A legibly typed or written autobiographical page, approximately 500 words, written by applicant, regarding his/her career choice, ambitions, long- and short-term goals, and any other information applicant wishes the committee to take into consideration.
4. Written verification from college of acceptance into a health-related department.

***PLEASE NOTE:

- If you do not fit the criteria at this time, but are accepted into a health-related undergraduate program in the future, please apply at that time or inquire by writing to the address above.
- Recipients may reapply each year for scholarship renewal, according to the criteria above.
- Scholarship payments will be made directly to the institution, not the recipient.
- **Completed applications with all attachments must be received at the address above on or before March 31 of the year of application.**

RETURN COMPLETED APPLICATION TO:

Lake County Medical Alliance
Scholarship Committee
Debbie McNaughton, Chairperson
11520 Gate Post Lane
Chardon, OH 44024

Health Careers Scholarship
Application Form

PERSONAL INFORMATION (Please type or print clearly)

Name_____

Address _____

Birth date _____ Phone _____

Are you a citizen of the USA? _____ If not, explain your status _____

Name of high school _____ Graduation date _____

SCHOOL/COLLEGE INFORMATION

Into what accredited, medically related program have you been accepted?_____

Name of school/college where you have been accepted _____

How many years remain in your chosen program to complete you undergraduate degree? _____

Expected month / year of graduation? _____

Anticipated expenses for the upcoming year of study: Tuition $_____

Room and board $_____

Other (please specify) $_____

FAMILY INFORMATION (Complete as applicable to your situation)

Name of parent(s) / guardian(s) _____

Father's occupation _____ Employer _____

Mother's occupation _____ Employer _____

Spouse's occupation (if married) _____Employer _____

Number in household ____Number in college in upcoming year ____ Are any parents/guardians in college now? ____

Do your parents /guardian / spouse support your plans for further study in your chosen program? _____

Total family income (gross: before deductions) $_____

Amount family is contributing toward family members currently in college $_____

ADDITIONAL FINANCIAL INFORMATION

Are you currently employed? Yes ___ No____ If so, how many hours per week? _____ Weekly earnings? $_____

Job title, name & address of employer _____

_____

Summer employment? Yes____ No ____ If so, how many hours per week? _____ Weekly earnings? $_____

Job title, name & address of employer _____

Total you expect to pay toward college expenses $_____

Amount from other sources (including tuition credits, etc.) $_____

List other scholarships / grants applied for and amounts, if known, that you will receive for the upcoming academic year from organizations other than your school/college

_____$_____

_____ $_____

OTHER PERSONAL INFORMATION

Please list (name of organization, offices held, if any, length of time of service) (Continue on separate sheet if necessary):

School and community activities / volunteer work _____

_____

Special honors, prizes, recognitions received while attending school or in the workplace _____

_____

_____

Hobbies / interests_____

PLEASE READ, SIGN, AND DATE

The LCMA Scholarship guidelines are enclosed with this application form. By signing, the undersigned acknowledges receipt of the guidelines and agrees to abide by such. The undersigned also agrees to waive all personal claims, causes of action, or damages against the Lake County Medical Alliance, its board members, officers, and associates thereof, arising from or growing out of their participation in the LCMA Scholarship program. In addition, the undersigned agrees to allow his/her name to be used for publicity purposes should he/she be awarded a scholarship.

My signature certifies that I have read, understand, and agree to the terms & conditions of this application and that all information provided on this application is correct. I also understand that said information is regarded as confidential and for the exclusive use of the LCMA Scholarship Committee for the purpose of determining scholarship awards.

STUDENT SIGNATURE _____ DATE _____

PARENT / GUARDIAN SIGNATURES _____ DATE _____

_____ DATE _____