2018 Partners Scholarship Application

Partners with Marshfield Medical Center
Marshfield, Wisconsin

Specifications:

1. Applicants must be a current/former registered VOLUNTEEN/VOLUNTEER at Marshfield Medical Center (Saint Joseph's Hospital) in Marshfield, Wisconsin.

2. Applicants must be enrolled or enrolling in a program of higher education.

3. Scholarship funds must be spent on tuition.

4. Financial need is considered but not mandatory.

5. A student is eligible to receive a Partners Scholarship twice.

6. All scholarship awards are for $1,000.

Application requirements:

1. Complete application on the **current year's application form only**.

2. High School applicants should attach a transcript (unofficial is accepted) of their most recent grades, including first semester senior grades. This should include a copy of their highest ACT/ SAT scores & GPA. Enrolled college students should attach their most recent ***official college transcript***.

3. Two completed Scholarship Recommendation Forms should be included with the application. At least one form should be completed by a teacher/professor. ***Applicant must use forms provided.***

4. On a separate piece of paper, describe your educational and career objectives including your future goals. Explain why you want to gain further education, how education will help you to meet your goals, and what your plans are once you complete the educational program. Also include any financial needs (please limit essay to one page).

5. Include a print-out of your Marshfield Medical Center (Saint Joseph's Hospital) volunteer hours, which are available through the Volunteer Services office.

6 All parts of the application should be ***submitted together***.

All applications must be completed and postmarked by March 1, 2018. Applications postmarked after this date will not be considered. Early applications are accepted and encouraged. Scholarship awards are recommended by the Scholarship Committee and approved by the Partners Board of Directors at its April, 2018, meeting. Awardees will be notified in May, 2018.
Applications must be postmarked by March 1, 2018.

MAIL TO: Laura Ptak
217 S. Schmidt Avenue
Marshfield, WI 54449

Questions? Contact Laura Ptak at 715-387-4512 or email at laura_ptak4@yahoo.com

Partners with Marshfield Medical Center
Marshfield, Wisconsin

2018 PARTNERS SCHOLARSHIP APPLICATION

CHECK ALL THAT APPLY: ____ High School Senior
____ Currently enrolled in a program of higher education
____ Marshfield Medical Center volunteen/volunteer

NAME _____

ADDRESS _____

CITY, STATE, ZIP_____

Home Phone Number_____ Cell Phone_____

EMAIL Address_____

HIGH SCHOOL attending/have attended_____

COLLEGE or UNIVERSITY you plan to attend/are attending_____

FIELD OF STUDY_____

If necessary, use additional sheets to provide the requested information:

PAID WORK EXPERIENCE (Please give a detailed account including length of employment and estimated hours worked.)

_____
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NON-PAID COMMUNITY INVOLVEMENT (i.e. church, civic organizations, scouting organizations, health-related activities, mentoring, tutoring, etc.) Explain your role in these activities and length of time involved.

EXTRACURRICULAR ACTIVITIES (School) – This should include High School activities for High School applicants, or College activities for applicants already enrolled in college. Please give a detailed account and specify any leadership roles you may have held.

VOLUNTEER/EMPLOYMENT ACTIVITIES AT Marshfield Medical Center

Please tell us about your volunteer/work experiences at Marshfield Medical Center. Describe how your volunteer/work experiences have influenced your life and career goals.

Partners with Marshfield Medical Center

Marshfield, Wisconsin

SCHOLARSHIP RECOMMENDATION FORM

Applicant: Please complete this portion of the form and then give it to the person who has agreed to write a recommendation for you.

Name of applicant: _____

I hereby authorize (name of reference) _____ to complete this form. I hereby waive my right to access the contents of this recommendation and further understand that information contained in this recommendation will only be used for the purpose for which it was prepared.

_____ _____

Signature of Student Date

Thank you for completing this recommendation. The student named above is applying for a Partners with Marshfield Medical Center Scholarship. Your comments and recommendations will be instrumental in verifying the applicant's qualifications for the scholarship. The deadline for applications is **March 1**; therefore, your prompt response is necessary to facilitate the student's chance of receiving the scholarship. **Please return this form in a sealed envelope to the student**. Any questions you have concerning the scholarship will be answered by Laura Ptak, Partners Scholarships Director, at 715-387-4512 or email laura_ptak4@yahoo.com

1. How long and in what capacity have you known the applicant?

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2. What is your assessment of the student's reliability?

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3. Please give a specific example of initiative shown by this student.

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4. How would you describe the applicant's communication skills?

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5. What academic and/or personal characteristics does this student demonstrate that will allow him/her to succeed in the future?

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_____ _____

Signature of person completing form Date

Partners with Marshfield Medical Center

Marshfield, Wisconsin

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