

**GUIDELINES**  
**for**  
**THE DELNOR-COMMUNITY HOSPITAL AUXILIARY**  
**ADULT EDUCATION SCHOLARSHIP**

Presented to an individual (18 and over) who (1) is presently enrolled in either an undergraduate or graduate program with a declared major in a health care field

**Or (2)** Is a High School graduate returning to a post secondary school to pursue a major in a health care field

**APPLICATION DEADLINE: June 13, 2010**

Dear Applicant:

The Delnor-Community Hospital Auxiliary is pleased to offer scholarship aid to a qualified applicant. Please read carefully the current guidelines and policies of our scholarship program before you complete the application.

I. Eligibility

1. Applicant must meet at least one of the following criteria:
  - a. Be a resident of the Delnor-Community Hospital primary service area (Geneva, St. Charles, Batavia, Wasco, Elburn, Kaneville and LaFox ).
  - b. Be a Delnor-Community Hospital employee (or child of an employee) or volunteer for at least two years.
  - c. Be a paid and active member of the Delnor-Community Hospital Auxiliary for at least two years.

Guidelines (continued)

2. Applicant must also meet one of the following criteria:
  - a. Applicant must be presently enrolled and in good standing in an undergraduate, graduate or professional health care program, and continuing that enrollment in 2010-2011.
  - b. Applicant must be a High School graduate and be returning to a post secondary school to pursue a health care curriculum in 2010-2011.
3. The school attended must be an accredited and approved program by appropriate agencies.

II. Facts Pertaining to Scholarship

1. Four adult scholarships in the amount of \$2,500 will be awarded in July based upon scholastic achievement, financial need, references, community service, and satisfaction of requirements listed in Section I.
2. Members of the Delnor-Community Hospital Auxiliary and hospital employees will be given first consideration by the Awards Committee.
3. The proceeds of the scholarship are to be applied toward tuition, fees, room, board and books. Upon receipt of verification of acceptance, a check from the Treasurer of the Auxiliary will be made payable to the school designated and mailed to the scholarship recipient for forwarding.
4. All applications will be confidentially reviewed by a Scholarship Selection Committee. Selections will be made in July and the recipients will be notified by mail. The decision of the committee as to allocation of the scholarships shall be final.
5. Should a recipient of the award decide not to continue at the designated school and/or pursue a degree in a healthcare field for any reason not approved by or deemed an emergency by the Scholarship Committee, THE AMOUNT OF MONEY AWARDED SHALL BE RETURNED TO THE SCHOLARSHIP FUND.

### III. Applicant Responsibility

1. Applications must be completed and filed with Linda Niemann, Volunteer Services, Delnor-Community Hospital, by June 13. Failure to complete any portion of the application will disqualify the application.
2. Should the applicant receive a scholarship, it will be his/her responsibility to submit a letter from the school he/she will be attending in the fall 2010. This letter should be submitted to Linda Niemann, Volunteer Services Department at Delnor-Community Hospital.
3. Applicant should especially note Item 5 in Section II (above).
4. All questions or correspondence should be addressed to  
Linda Niemann, Volunteer Services,  
Delnor-Community Hospital  
300 Randall Road  
Geneva, Illinois, 60134  
(Volunteer Services 630 208-4265).

Sincerely,

Sue Jensen, Diane Skidmore-Dailey  
& Sharon Kettley Scholarship Chairpersons  
Delnor-Community Hospital Auxiliary

Social Security No. \_\_\_\_\_

**THE DELNOR-COMMUNITY HOSPITAL AUXILIARY  
ADULT EDUCATION SCHOLARSHIP  
APPLICATION FOR SCHOLARSHIP**

**Part I:** To be completed by applicant.

Name of Applicant \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address \_\_\_\_\_ Phone: \_\_\_\_\_

Field of Study \_\_\_\_\_

**Current Students:**

School attending (include copy of most recent transcript):

\_\_\_\_\_  
\_\_\_\_\_

Degree/Certification receiving: \_\_\_\_\_

Graduation Date \_\_\_\_\_

**New Students:**

Health care field/career for which applicant returning to school: \_\_\_\_\_

School to attend and Entrance date: \_\_\_\_\_

**Current Students and New Students:**

Experience, if any, related to proposed career:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

High School Attended (include copy of transcript):

Address:

\_\_\_\_\_

Colleges/Professional Schools Attended:  
(include transcript from most recent school)

Attendance Dates

Degree

Colleges/Professional Schools Attended: (include transcript from most recent school)	Attendance Dates	Degree
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ADULT EDUCATION SCHOLARSHIP (CONTINUED)**

**Part I: (Continued)**

**Work History:**

<u>Employer</u>	<u>Address</u>	<u>Dates of Employment</u>

**Community Involvements:** (list groups & your participation)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Activities/Interests:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Brief statement as to why you've chosen career indicated:**

Please attach a brief statement (no longer than one page) why you are returning to school and going into the healthcare field you have chosen. Please be sure your name is on the statement.

**References:** (2 people other than relatives to whom a request for reference is made. Have each complete **Part IV**)

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

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It is understood by the Applicant that granting of financial aid will be dependent upon his or her present enrollment in a school approved by the Awards Committee and further that should the applicant discontinue his or her study in the designated field for any reason not deemed an emergency by the Awards Committee, THE AMOUNT OF MONEY AWARDED SHALL BE RETURNED TO THE SCHOLARSHIP FUND.

\_\_\_\_\_  
Applicant's Signature

**THE DELNOR-COMMUNITY HOSPITAL AUXILIARY  
ADULT EDUCATION SCHOLARSHIP**

APPLICATION FOR SCHOLARSHIP

Part II:

Name of Applicant: \_\_\_\_\_ O Married O Single O Divorced

Address: \_\_\_\_\_

Name & Address of Employer: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Position Held: \_\_\_\_\_ Annual Salary \_\_\_\_\_

Federal income Tax paid last year \_\_\_\_\_

Spouse's Name: (if Applicable) \_\_\_\_\_

If spouse is employed, name and address of his/her employer: \_\_\_\_\_  
\_\_\_\_\_

Position Held: \_\_\_\_\_ Annual Salary: \_\_\_\_\_

Federal Income Tax paid last year if filed separately from above: \_\_\_\_\_

If applicant was claimed as a dependent last year:

Individual claiming applicant \_\_\_\_\_

Relationship \_\_\_\_\_ Position Held \_\_\_\_\_

Annual Salary \_\_\_\_\_ Federal Income Tax Paid last year \_\_\_\_\_

List of Applicant's dependents:

Name	Age	Relationship
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1. _____	_____	_____
----------	-------	-------

2. _____	_____	_____
----------	-------	-------

3. _____	_____	_____
----------	-------	-------

4. _____	_____	_____
----------	-------	-------

Brief statement of any facts concerning special financial problems relevant to need of scholarship aid:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**THE DELNOR-COMMUNITY HOSPITAL AUXILIARY**  
**ADULT EDUCATION SCHOLARSHIP**

**APPLICATION FOR SCHOLARSHIP AID**

**Part III:** To be completed by applicant.

ESTIMATED EXPENSES OF APPLICANT FOR ACADEMIC YEAR 2 \_\_\_\_ to 2\_\_\_\_.

\*Tuition . . . . . \$ \_\_\_\_\_  
Room and Board . . . . . \$ \_\_\_\_\_  
Books and Supplies . . . . . \$ \_\_\_\_\_  
Clothes . . . . . \$ \_\_\_\_\_  
Transportation . . . . . \$ \_\_\_\_\_  
Incidentals . . . . . \$ \_\_\_\_\_  
  
TOTAL            \$ \_\_\_\_\_

ESTIMATED RESOURCES AVAILABLE

Applicant's own funds . . . . . \$ \_\_\_\_\_  
Other . . . . . \$ \_\_\_\_\_  
Loans, give details . . . . . \$ \_\_\_\_\_  
Other scholarships, if any . . . . . \$ \_\_\_\_\_  
  
TOTAL            \$ \_\_\_\_\_

Balance needed for year . . . . . \$ \_\_\_\_\_

Must be signed by applicant:

\_\_\_\_\_  
Applicant's Signature

- Please submit appropriate evidence of current tuition costs and other educational fees (i.e. a copy of the school catalogue, computer printout, or a letter from the school giving this information).

**THE DELNOR-COMMUNITY HOSPITAL AUXILIARY**  
**ADULT EDUCATION SCHOLARSHIP**

**APPLICATION FOR SCHOLARSHIP**

In order to ensure anonymity in the selection process please limit the use of the applicant's proper name in your reference. It is important that you understand that personal references are **often** the determining factor in deciding who will receive this scholarship. We appreciate the time you take to tell us more about this applicant's qualifications for this award.

**Part IV:** To be completed by personal reference.

**Applicant's Name:** \_\_\_\_\_

**How long have you known applicant?** \_\_\_\_\_

**In what relationship?** (teacher, employer, colleague, etc.)  
\_\_\_\_\_

Please attach a brief statement (no more than one page) about the applicant (character, abilities, attitudes, interests, work ethic, deportment, etc.). What are the applicant's strong points? What makes the applicant stand out?

Why do you think this applicant would be successful in a health care field?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any additional comments?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALL REPLIES ARE STRICTLY CONFIDENTIAL**

**Return by June 13 to:**  
Linda Niemann  
Volunteer Services Department  
Delnor-Community Hospital  
300 Randall Road  
Geneva, Illinois 60134  
630-208-4264 fax 630-208-3479

\_\_\_\_\_  
Signature of Person Providing Reference  
  
\_\_\_\_\_  
Address  
  
\_\_\_\_\_

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**ADULT EDUCATION SCHOLARSHIP**

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any additional comments?  
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\_\_\_\_\_  
\_\_\_\_\_

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