HSHS ST. ANTHONY'S MEMORIAL HOSPITAL AUXIARY SCHOLARSHIP GUIDELINES

1. The applicant must attend an accredited Illinois college working toward a degree related to the medical field.
2. The Scholarship Committee reserves the right to make judgment in cases not covered by the guidelines.
3. Students must maintain a 2.0 grade point average. **Transcript required for most current year.**
4. Payment of all scholarships is made in two installments. The first half of payment will be made by July 31 to the school. The second half will be made no earlier than January 1 – upon receipt of the student's fall grades transcript.
5. Scholarship applicants must be postmarked by **April 1**.
6. All applications will receive a letter by July 1 indicating whether or not they are the recipient of the scholarship.
7. A photo must be attached to the signed photo consent. These photos will be used by the HSHS St. Anthony's Memorial Hospital Auxiliary for publicity purposes. If an applicant is not accepted for a scholarship, the photo will be returned.
8. If for any reason the applicant is unable to enroll, the awarded scholarship is to be returned in full to the Auxiliary Treasurer.
9. The Auxiliary Coordinator at HSHS St. Anthony's Memorial Hospital will receive the application – keeping the cover page until the scholarship winners have been chosen so that the Scholarship Committee will not know the identity of the applicants until after the selection has been made.

APPLICATION FOR HSHS ST. ANTHONY'S MEMORIAL HOSPITAL AUXIARY SCHOLARSHIP

Please type or print. The completed application must be postmarked by **April 1** and sent to:

HSHS St. Anthony's Memorial Hospital
Attn: Auxiliary
503 N. Maple Street
Effingham, IL 62401

Date of application ____

Name ____

Last First Middle

Address ___________________________ City _____________ State ______ Zip ________

Telephone Number ________________________ Email ____________________________

Please attach a recent photo to this page and sign the photo consent.

APPLICATION FOR HSHS ST. ANTHONY'S MEMORIAL HOSPITAL AUXIARY SCHOLARSHIP
(Additional sheets may be used)

List names of high school(s) attended and number of years at each: ________________________

____

Name and address of college you plan to attend: ____

____

Name of course of study or major you plan to take: ______________________________________

What license, certificate, or degree is granted on completion? ____________________________

What are your employment goals/plans? ____

____

List other honors and awards received: ____

____

List school activities: ____

List community activities: ____

____

List your work experience: ____

Please attach the most current grade transcript.

Please provide two (2) non-family letters of recommendation.

Please attach a short essay (approximately 150 words) stating your educational goals and how this scholarship will help you attain these goals.

Consent to Film, Photograph, Record and Quote

I hereby give my permission to Hospital Sisters Health System (HSHS), HSHS St. Anthony's Memorial Hospital or its affiliates to film, photograph, record or quote me, and to publish photograph or tapes of me, or quotes by me, with or without my name. Additionally, I authorize HSHS, St. Anthony's Memorial Hospital, its affiliates, news/media organizations, and/or other organizations as determined by St. Anthony's Memorial Hospital to publish statements, quotations, or summarized excerpts from any interview(s) conducted with me in whole or in part for advertising, news, promotion, fundraising, and/or educational purposes, such as presentations, and publications. I further authorize St. Anthony's Memorial Hospital to cooperate with the news media in the preparation of a news story by releasing information about me and/or filming or photographing me. Publication may occur now or at any time in the future, may be in various forms of media (print, television/radio, Internet) and may be for any editorial, promotional, advertising, fundraising, trade or other purpose.

______________________________	______________________________
Name of Subject (Please Print)	Street Address (Please Print)
______________________________	______________________________
City, State, Zip Code	Date
______________________________	______________________________
Signature of Consenting Party*	Name of Signer if Subject is a Minor (Please Print)
______________________________	______________________________
Signature of Witness	Project

***Instructions:** The consent form should be signed by the patient if an adult (18 years or older), by a parent or court-appointed guardian if the patient is a minor or by a court-appointed guardian if the patient has been declared legally incompetent. (This form need not be completed if filming or photography is incidental to a surgical or medical procedure for which a general informed consent form is completed.)