**Liberty Hospital/Liberty Hospital Foundation**

**2021 Nursing Scholarship Application**

**INSTRUCTIONS: Copy this document to your own computer – fill in fields – print and submit with other required materials.**

**I.   Personal Information**

**Please complete the following personal information:**

**Last Name:**

**First Name:**

**Home Address****:**

Street                                     City                             State Zip Code

**Home Telephone Number:**       **Cell Phone Number:**

**Email address:**       **Birthdate:**

**How did you learn about this scholarship?**

Do you have any relatives employed by New Liberty Hospital District (“Liberty Hospital”) or the Liberty Hospital Foundation?   Yes [ ]  No [ ]   If yes, please state the name(s) and relationship:

**II. Family information**

**Father/Guardian full name****:**       **Mother/Guardian full name****:**

**St. Address****:**       **St. Address:**

**City:**       **State:**       **Zip****:**       **City:**       **State:**       **Zip****:**

**Father’s Occupation:**       **Mother’s Occupation****:**

**# of Siblings (not including applicant):**       **# in College****:**       **# K-12****:**

**Siblings names** **If Attending College - Where and Year in School**

1.

1.

1.

1.

Do you live with your parents? [ ]  Or with a Single parent [ ]  Other [ ]  Explain:

**III. Extra Curricular Activities and Work Experience**

**Please list your participation in non-medically focused activities (including sports, extracurricular and/or academic clubs), community, church, and service organizations as well work experience over the last four (4) years:** Please indicate years of involvement, offices held, honors and awards received. Please contain answers to table below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Organization/Activity Name** | **School Year 2017-2018** |  **2018-2019** |  **2019-2020** |  **2020-2021** | **Involvement/Leadership role** |
|       | [ ]  | [ ]  | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  | [ ]  | [ ]  |       |
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|       | [ ]  | [ ]  | [ ]  | [ ]  |       |

**Please list your participation in medical- or nursing- focused efforts (including: extracurricular or academic clubs (ex – HOSA), organizations, medical-related volunteering, internships (ex – Northland CAPS), work experience) over the last four (4) years:** Please provide a brief description of your activities and contain answers to table below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Organization/Activity Name** | **School Year 2017-2018** |  **2018-2019** |  **2019-2020** |  **2020-2021** | **Brief Description** |
|       | [ ]  | [ ]  | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  | [ ]  | [ ]  |       |
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|       | [ ]  | [ ]  | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  | [ ]  | [ ]  |       |

**Have you participated in Northland CAPS, Project Lead the Way, or similar learning experiences? If no, please indicate why.:**

**Do you plan to work during the school term?**:       **Hours per week****:**

**IV.  High School Academic Information**

**High School Attended:**

                                         Name                              Address Graduation Year

**Class Rank:**      **/**          **GPA (MUST BE 3.0 or higher to apply):**       **Weighted GPA:**

**ACT Results**

**Raw score:**           **English****:**       **Math****:**       **Reading****:**       **Science****:**       **Composite****:**

**Other test scores you wish to report (SAT cumulative and raw scores, Advanced Placement exams, etc.)**:

**Name of High School Counselor****:**       **Phone number****:**

**V. College Plans**

**Name(s) of College(s) you applied to or have been accepted to:**

**Name** **of College you plan to attend:**

**Have you been accepted to the Nursing Program?****:** Yes [ ]  Waiting to hear [ ]  Can’t apply yet [ ]

**If can’t apply yet, when can you be accepted to the Nursing Program?:**

**Field of interest:**

**Month/Year you expect to graduate****:**    **/**

**College credit awarded/in progress-Classes taken**:      **College awarded/ing:**

**References, Transcripts, And Reasons For Applying For Nursing Scholarship:**

Please submit ONLY THESE ITEMS with this Application IN THE ORDER LISTED:

* Official high school transcripts (and college if applicable)
* Verification of acceptance to College or University and acceptance to nursing if received
* A personal statement describing your background, personal interests, strengths, and why you’ve chosen the nursing profession as a career.  Please explain what qualities you have which would allow you to be an outstanding health care provider.  Include examples of when you have demonstrated these qualities.
* Two sealed letters of recommendation – one from a scholastic source and one from a personal source – on letterhead and signed – with signature across back of envelope

**VI.   Acknowledgement:**

I certify that I have read the foregoing Scholarship Application and the Liberty Hospital/Liberty Hospital Foundation Scholarship Application Guidelines, that I understand the questions, that the answers I have given are true, accurate and complete, and that I have made no false statements nor have I misrepresented any facts in this application, and that I authorize investigation of all my statements contained in this application.  I understand that false answers will disqualify me from consideration for a scholarship. I hereby release the New Liberty Hospital District (“Liberty Hospital”) and the Liberty Hospital Foundation, their respective officers and agents, committee members, and employees from any liability resulting from any investigation of my statements contained in this application that I have hereby authorized by my signature below

Liberty Hospital/Liberty Hospital Foundation will not discriminate in any respect on any application for funding under the Liberty Hospital/Liberty Hospital Foundation Scholarship Award Program because of an applicant’s race, sex, age, national origin, religion, physical or mental impairment, or veteran status.

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Signature of Applicant                                                                                            Date

**Application Deadline**:  **March 8th**

**Please send all materials to:**

**Liberty Hospital Foundation**

**ATTN: Maddison Watkins**

**PO Box 1002**

**Liberty, MO  64069-1002**

**816-792-7014**

**foundation@libertyhospital.org**