SSMHealth®
Ripon Community Hospital

2024 Scholarship Application

SPONSORED BY THE RIPON COMMUNITY HOSPITAL MEDICAL STAFF

1 PERSONAL DATA

Name: ______________________________ Telephone Number: (_______) ______________

Address: ______________________________ County: ______________

City: ______________________________ State: ________ Zip: ______________

Parents or Guardians: ______________________________

Occupation of Father: ______________ Occupation of Mother: ______________

Number of Siblings and Ages: ______________________________

Name of School Currently Enrolled In: ______________________________

Health Care Career You Are Considering: ______________________________

Institutions for Which You Have Applied or Are Currently Enrolled At: ______________________________

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2 FINANCIAL DATA

To enable the committee to select scholarship recipients, it is necessary to evaluate financial need, as well as scholastic achievements, character, etc. For this reason, you are asked to provide the following information which will be treated as confidential.

A. List your total expenses for your 2024-2025 year of schooling using cost data provided by the institution you plan to attend.

Tuition ______________ Books ______________

Housing ______________ Other ______________

B. How much can you provide toward this from your own earnings and/or savings? $ ______________

C. How much will your parents provide financially per year? $ ______________

3 SHORT WRITTEN ESSAY (Answer the following questions, not exceeding two typewritten double-spaced pages.)

A. Why are you choosing to enter this health care field?
B. To date, what have you done to demonstrate your interest in this health field?
C. Describe how you have made a difference in school or in your community.
D. How do you plan to finance your education?
E. Are you, or will you be, a first-generation college student?

4 CO-CURRICULAR & SERVICE ACTIVITIES

List the co-curricular and service activities in which you participated, and any offices held or honors received while in high school or college.

ACTIVITIES:	YEARS PARTICIPATED:

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5 WORK EXPERIENCE List any jobs held.

JOBS	DATES

6 REFERENCES

Please list the names of three people as references for you. No more than one person may be a teacher in the high school you are attending. Your references may be contacted by the committee.

NAME	OCCUPATION	ADDRESS & ZIP	TELEPHONE

I AFFIRM THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: ______________________________ **Date:** ____________________

All portions of this application must be completed and mailed with your essay, as well as a transcript of your high school grades, to the address listed below:

CONTACT: Nicole Peters
Medical Staff Office
430 E. Division Street
Fond du Lac, WI 54935

ALL APPLICATIONS MUST BE POSTMARKED NO LATER THAN MARCH 15, 2024.

Scholarships awarded will be directed to the student's high school or educational institution.