McLeod
Regional Medical Center

Auxiliary Scholarship Application

DEADLINE - Application and required documents must be submitted to the Volunteer Services Office by **5pm on June 5th**

1. PERSONAL INFORMATION (Applicant)

Name: _____ DOB: _____ Age:_____

Address: _____ City:_____ State:_____ Zip _____

Cell phone#: _____ Home phone#: _____

Email:_____ SSN:_____ Student ID:_____

PARENT 1:

Name:_____ Cell Phone#: _____

Email address:_____ Work Phone#:_____

Employer: _____ Occupation:_____

PARENT 2:

Name:_____ Cell Phone#: _____

Email address:_____ Work Phone#:_____

Employer: _____ Occupation:_____

2. EDUCATIONAL BACKGROUND

_____

Name of High School(s) Address Current grade

Name of college, university, or technical school you plan to attend in the **fall of 2023**:

_____

Name of college, university, or technical school attending:

_____

Name of College/University/Technical College Location Semesters completed

Major or area of specialization: _____

Scholastic standing: Accumulated GPA (must be 3.5 or higher): _____

Aptitude or Achievement test: SAT Score: _____ ACT Score: _____

In what area of health care do you plan to pursue as a career? _____

3. ACTIVITIES

List school activities or organizations in which you participated. Include offices held in local, state, or national organizations: _____

_____

_____

Community Activities: _____

Please list any awards, honors, scholarships, etc. you have received: _____

_____

_____

4. FINANCIAL INFORMATION

Name of school, address of its Financial Aid office, and course of study you plan to pursue for your healthcare related career and for which you are requesting financial assistance
(include acceptance letter.)

School Name and address: _____

Student ID #: _____

Course of Study: _____

Financial Assistance: _____

Projected Graduation Date: _____

How much is tuition for one semester? _____

List amount and source of funds that will be available for your education for one semester: (Required)
Self: $_____ Relatives: $_____

*List all scholarships and amounts, plus pending scholarships:_____

_____

_____

Are you receiving any other funding from McLeod Health? If so, how much?_____

_____

_____

5. VOLUNTEERING INFORMATION

Volunteerism is an important part of life. Please share with us your volunteer experiences.

_____

_____

Volunteer Activities: _____

APPLICANT'S SIGNATURE:_____ DATE:_____

PARENT/GUARDIAN SIGNATURE:_____ DATE:_____

McLeod

Regional Medical Center

Note: (Please supply envelope and stamp for reference.)

I,_____, am applying for a health-related scholarship from the McLeod Regional Medical Center Auxiliary. I hereby authorize the release of the requested information to the McLeod Volunteer Auxiliary.

_____ _____

Signature Date

==========

1. When did you first know the applicant? From _____ To_____

2. What is your relationship to the applicant? (No relatives)

____ Supervisor/Employer ____ Guidance Counselor

____ Teacher ____ Coach

3. Please describe the applicant in terms of quality of work, dependability, cooperation, initiative, and attitude.

_____

_____

_____

_____

_____

Additional comments:_____

_____

SIGNATURE:_____ Date:_____

_____ _____ _____

Street or P.O. Box City, Sate, Zip Code Phone Number

Email address:_____

Please mail this form directly to:
VOLUNTEER SERVICES, SCHOLARSHIP COMMITTEE
McLeod Regional Medical Center
P.O. Box 100551, Florence, SC 29502-0551
BY: JUNE 5TH PRIOR TO FALL TERM

McLeod

Regional Medical Center

Note: (Please supply envelope and stamp for reference.)

I,_____, am applying for a health-related scholarship from the McLeod Regional Medical Center Auxiliary. I hereby authorize the release of the requested information to the McLeod Volunteer Auxiliary.

_____ _____

Signature Date

==========

2. When did you first know the applicant? From _____ To_____

2. What is your relationship to the applicant? (No relatives)

____ Supervisor/Employer ____ Guidance Counselor

____ Teacher ____ Coach

3. Please describe the applicant in terms of quality of work, dependability, cooperation, initiative, and attitude.

_____

_____

_____

_____

_____

Additional comments:_____

_____

SIGNATURE:_____ Date:_____

_____ _____ _____

Street or P.O. Box City, Sate, Zip Code Phone Number

Email address:_____

Please mail this form directly to:
VOLUNTEER SERVICES, SCHOLARSHIP COMMITTEE
McLeod Regional Medical Center
P.O. Box 100551, Florence, SC 29502-0551
BY: JUNE 5TH PRIOR TO FALL TERM

McLeod

Regional Medical Center

Note: (Please supply envelope and stamp for reference.)

I,_____, am applying for a health-related scholarship from the McLeod Regional Medical Center Auxiliary. I hereby authorize the release of the requested information to the McLeod Volunteer Auxiliary.

_____

Signature Date

==========

3. When did you first know the applicant? From _____ To_____

2. What is your relationship to the applicant? (No relatives)

____ Supervisor/Employer ____ Guidance Counselor

____ Teacher ____ Coach

3. Please describe the applicant in terms of quality of work, dependability, cooperation, initiative, and attitude.

_____

_____

_____

_____

_____

Additional comments:_____

_____

SIGNATURE:_____ Date:_____

_____ _____ _____

Street or P.O. Box City, Sate, Zip Code Phone Number

Email address:_____

Please mail this form directly to:
VOLUNTEER SERVICES, SCHOLARSHIP COMMITTEE
McLeod Regional Medical Center
P.O. Box 100551, Florence, SC 29502-0551
BY: JUNE 5TH PRIOR TO FALL TERM