18614 Jackson St., PO Box 125 ● Hermitage, MO 65668 phone 417.745.2121 ● fax 417.745.2032 ● www.ozarkschc.com

Scholarship Application

APPLICANT PLEASE READ: Thank you for your interest in a scholarship from Ozarks Community Health Center. Your application will receive consideration without regard to race, sex, national origin, age, physical or mental impairment or veteran status.

PLEASE NOTE: Any application that is turned in incomplete will not be accepted. For your convenience, there is a check list on page three of this application. Please follow all directions while completing this application and answer all questions as carefully, completely and honestly as possible.

PLEASE PRINT) last name		me		middle initial		
number and street	city	state	zip code	telephone number	county	
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the application, before the Fe	ebruary 28 " deadime.					Graduation Date
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Name of Contact Person			Title of Contact Person Telephone		e	
Academic Year Applied For	Student's Current Year in th	ne Program	Program Start Date	2	Projected	l Graduation Date
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EDUCATIONAL OBJECTIVE

What certification or	licensure will you be eligib	le for upon completion of this program?
How did you become	interested in our Scholarsh	nip?
Why do you seek a sc	holarship from Ozarks Com	nmunity Health Center?
-	•	eve would be helpful to the Scholarship Selection Committee ds, honors, volunteer activities, etc).
statement should not e	application, a personal statem sceed one single-spaced type lealth care as a profession, in	ERSONAL STATEMENT nent describing your commitment to provide healthcare in Missouri. This written page. The personal statement should reflect your personal cluding your professional goals. Enclose the original personal statement
we would like for them need to submit the form	to fill out. Please make copie n to you in a sealed envelope, our application to be conside	REFERENCES ed to turn in with your application. The back page is an example of what es of this back page and give to the references of your choice. They will, with the envelope flap signed by the reference. You will need to submit red for this scholarship. PPLICATION CHECKLIST
COMPLETE	COMPONENTS	
NOTE: All documents su	ıbmitted must be original. Faxed	d or e-mailed documents will not be accepted.
	All sections of the applicat	ion completed
		pleted and signed by a school representative
	 application signed and d 	
		sed reflecting personal reason(s) for choosing health care as a profession
		closed in sealed envelopes, with the envelope flap signed by the reference
	Original high school transc	•
the applicant. Failure to when scored.	onsibility to ensure all componer o submit a complete application	anscript(s) enclosed, if applicable nts of Scholarship Application are complete. This checklist is provided to assist may result in the application being deemed ineligible or in a reduction of points rtify that I have read the foregoing application, which I understand the questions,
which the answers given materially false answer Community Health Cent statements contained in	n are true and authorized investi will disqualify me from considera er, its agents and employees fro	gation of all statements contained in this application. I understand that a ation for a scholarship from Ozarks Community Health Center. I release Ozarks m any liability resulting from such investigation, and I authorize investigation of all
Printed Name of Applicant		Applicant Signature
Date		

Please complete this form as accurate and honestly as possible. After you have completed this for completed recommendation in an envelope, seal and sign your name across the seal of the envelop envelope to the applicant. The applicant will return the sealed envelope with his or her application 28th deadline. How well do you know this applicant?						
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Printed Name Business and Position (if applicable)						

Home Telephone Number

Address

Work Telephone Number