The Cherokee Regional Medical Center Auxiliary awards scholarships annually to assist area students entering a human health occupation career.

The scholarships are in the amount of $400. This amount must be repaid to the hospital auxiliary if the course of study is not completed or the recipient does not enter the school of choice by October 1 of the year the scholarship is received.

Applications must be returned to the Auxiliary by April 1 of each year. Applications will be reviewed by Auxiliary members and a decision reached by late April. Scholarships will be presented to the recipients at the Auxiliary May Coffee. If no applicants are qualified, the scholarship will not be awarded.

This scholarship is based on both financial need and overall high school performance.

**Student eligibility will be judged on the following:**

1. Applicant must be a resident of the Cherokee Regional Medical Center area.
2. Applicant must be a high school senior in good standing.
3. Use of the scholarship is limited to studies relating to a human health care occupation/career in a hospital or medical clinic in/outpatient setting.
4. The need for financial assistance is a consideration of the committee.
5. Applications must be submitted by April 1.
CHEROKEE REGIONAL MEDICAL CENTER AUXILIARY
SCHOLARSHIP APPLICATION

1. Name ________________________________

2. Address ________________________________

3. Phone ________________________________

4. Birth date ________________________________

5. Parents’ Names ________________________________

6. Parents’ Occupations: Father ________________________________
                Mother ________________________________

7. Number and ages of siblings ________________________________

8. How many of these siblings are attending college or receiving advanced education at this time? __________________

9. Graduation Date ________________________________

10. High School ________________________________

11. Health Occupation Career Goal ________________________________

12. College(s) or Program(s) to which you have applied for admission ________________________________

13. College(s) or Program(s) to which admission has been accepted ________________________________
    If not accepted, please explain ________________________________

14. Have you applied for other scholarships or loans? ________________________________

15. Have you been granted any other scholarships? ________________________________

16. List any extracurricular school and community activities ________________________________

17. What is your grade point average? ____________
Please attach:

1. A copy of your scholastic records showing class rank, ACT scores, GPA, and yearly classes and grades
2. An essay on “Why I am Entering a Health Career” (150 word minimum)
3. Three completed forms of recommendation
4. A billfold size picture of yourself

Please let us know the best way to contact you:
☐ Home Phone: ______________________________
☐ Cell Phone: ______________________________ Text ☐ Yes ☐ No
☐ Email Address: _________________________________________________________

The above completed application is true and valid.

_______________________________________________
Signature of Applicant

I am in support of my son’s/daughter’s application.

_______________________________________________
Signature of Parent

Completed application including attachments and recommendations due by April 1, 2024.

Return to:

Cherokee Regional Medical Center
Attn: Auxiliary Scholarship Committee
300 Sioux Valley Drive
Cherokee, IA  51012
Candidate Name: _________________________________________________________________

Describe the capacity in which you have known this candidate:

______________________________________________________________________________

______________________________________________________________________________

Comment on the candidate’s strengths to be a successful health career professional:

______________________________________________________________________________

______________________________________________________________________________

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______________________________________________________________________________

Add any additional information that you believe we would want to have in considering this candidate:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Signature __________________________________________ Date ______________
Candidate Name: _________________________________________________________________

Describe the capacity in which you have known this candidate:

__________________________________________________________________________

__________________________________________________________________________

Comment on the candidate’s strengths to be a successful health career professional:

__________________________________________________________________________

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Add any additional information that you believe we would want to have in considering this candidate:

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Signature ______________________________  Date ____________________