

**Applicant Name** \_\_\_\_\_  
Last First

**School (currently attending)** \_\_\_\_\_

## ST. MARY MEDICAL CENTER AUXILIARY 2026 COLLEGE STUDENT SCHOLARSHIP APPLICATION

### To submit your application:

- Return application in person to the Gift Shop, volunteer by the deadline **Friday, May 15th, at 2:00 PM.**

Carefully review the **St. Mary Medical Center Auxiliary 2026-2027 Scholarship Program Guidelines** before completing this application. Neatness is essential. An incomplete packet will be disqualified upon receipt. Be certain to sign and date the last page of the application. This application is five (5) pages.

### Application Checklist:

\_\_\_\_\_ If the applicant is an employee, employee dependent, volunteer, or direct descendent of an active adult volunteer in good standing, a photocopy of the employee's or volunteer's badge is required. Employees must meet the criteria for employee dependency to qualify (St. Mary Medical Center Auxiliary 2026-2027 Scholarship Program Guidelines). Applicants may apply to only one system hospital for a scholarship.

\_\_\_\_\_ Official transcript\* from your school. Spring transcripts should be submitted prior to interviews if the applicant qualifies. **\*Transcript must be official.**

\_\_\_\_\_ Two letters of recommendation in support of your application; both should be professional recommendations. Professional Recommendations must be signed and placed on official letterhead.

\_\_\_\_\_ A typed essay reflecting goals, accomplishments, and/or challenges encountered in the past year. Has the path to attain those goals changed since starting college? What involvement did you have within the community in the last year? Please include any information you think we should know that would assist us in the decision-making process.

For questions, please call the office of Volunteer Services at 219-947-6011.

# ST. MARY MEDICAL CENTER AUXILIARY SCHOLARSHIP

## COLLEGE APPLICANT INFORMATION

Name: \_\_\_\_\_  
Last First Middle

Permanent Address: \_\_\_\_\_  
Street City State Zip Code

Date of Birth: \_\_\_\_\_

Phone #: (home) \_\_\_\_\_ (cell) \_\_\_\_\_

Email: \_\_\_\_\_

Preferred means of communication: \_\_\_\_\_

## COLLEGE/UNIVERSITY/TECHNICAL SCHOOL INFORMATION

School Currently Enrolled

\_\_\_\_\_

School Address

\_\_\_\_\_

Phone Number

\_\_\_\_\_

Other outside scholarship(s) you have received or expect to receive (if known at this time):

Name/Source of Scholarship: \_\_\_\_\_

Name/Source of Scholarship: \_\_\_\_\_

Name/Source of Scholarship: \_\_\_\_\_

Major Field of Study: \_\_\_\_\_

**UNIVERSITY ACTIVITIES:**

University Activities

Leadership Positions/Awards

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**Elaborate on the responsibilities in your role in:**

**UNIVERSITY ACTIVITIES:**

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**EMPLOYMENT/WORK STUDY EXPERIENCE:**

Employer

Number of Hours Worked Per week

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**Elaborate on the responsibilities you acquired during your role in:**

**EMPLOYMENT EXPERIENCE:**

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**COMMUNITY INVOLVEMENT:**

Grade Level	Community Involvement	Number of Hours Completed Per Week
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Elaborate on the responsibilities you acquired during your role in:  
COMMUNITY INVOLVEMENT:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you feel that your grades are an accurate indication of your ability to succeed in college?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No

Briefly explain why the above answer was chosen:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IMPORTANT**

**PLEASE READ THE STATEMENT BELOW AND SIGN THE APPLICATION. THIS APPLICATION IS NOT COMPLETE WITHOUT THE SIGNATURE OF THE APPLICANT, PARENT OR GUARDIAN VERIFICATION.**

I affirm that the information submitted as a part of, and in support of, this application is complete and correct. I agree to report any changes in this information to the St. Mary Medical Center Auxiliary Scholarship Committee. I understand that if any person knowingly makes a false statement or misrepresentation in this application or any information submitted in support of this application, any financial assistance awarded shall be subject to cancellation, and I will be liable for repayment of financial assistance received or paid for my benefit. I agree that if I am selected to receive financial assistance, I will sign the St. Mary Medical Center Auxiliary Scholarship Committee acceptance contract and provide a current photograph of myself for marketing purposes. Furthermore, I authorize Powers Health to utilize this information for public relations purposes.

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Today's Date**

**PARENT OR GUARDIAN VERIFICATION (IF UNDER 18 YEARS OF AGE)**

The undersigned, being a parent or guardian of the student making the foregoing application, hereby certifies to the St. Mary Medical Center Auxiliary Scholarship Committee that I have read the foregoing application and reviewed the documents and other information to be submitted with the application that the information contained in the application and in the supporting submissions is true and accurate in every respect and that the student applicant is my legal dependent. I agree to submit any additional documentation to prove or verify the application and/or submissions made therewith, if requested by the Trustee or the St. Mary Medical Center Auxiliary Scholarship Committee, including, but not limited to, proof and verification of the applicant's dependence on me for principal support and maintenance. I agree to allow the Volunteer Services Department of St. Mary Medical Center to verify my employment with Powers Health Human Resources. Furthermore, I authorize Powers Health to utilize this information for public relations purposes.

\_\_\_\_\_  
**Signature of the Parent or Guardian**

\_\_\_\_\_  
**Today's Date**

\_\_\_\_\_  
**Printed Name**