2024 APPLICATION FOR AUXILIARY SCHOLARSHIP
MERCYONE CENTERVILLE AUXILIARY

Application must be returned by **April 5.** Please return completed application to the Administration office at MercyOne Medical Center – Centerville or mail to **MercyOne Centerville Medical Center, ATTN: Barbara Brown, One St. Joseph Drive, Centerville, IA 52544 or by email: barbara.brown004@mercyoneiowa.org** If you have any questions, you may contact Barbara Brown, MercyOne Administrative Assistant at 641-437-3441.

2 CHARACTER REFERENCES REQUIRED **Please forward the attached character reference form to 2 NON-FAMILY persons who can provide a reference for you. This form will be submitted separately by those references. Please DO NOT include with your application submission.**

APPLICANT'S NAME_____

Date of Birth_____

Permanent Mailing Address: _____

_____

_____

Phone Number: _____

_____
Signature Date

APPLICANT BACKGROUND INFORMATION

High School attended: _____

Year Graduated: _____

College(s) attended with dates: _____

_____

Major: _____ Degree obtained: _____

College you are planning to attend or are currently attending: _____

Have you been accepted for admission? _____Yes _____No

Comment: _____

Degree to be obtained: _____

Other scholarship or financial aid already acquired: _____
_____

Would you consider returning to Centerville, after graduation, to work in your field: _____ Yes _____ No

Have you received other education assistance from MercyOne Centerville Auxiliary: _____ Yes _____ No

If yes explain including dates: _____

_____

In the last year, have you done volunteer work or community service (please describe): _____

_____

_____

_____

List Work Experience: _____

_____

Please share your inspiration for entering the field of health care and how the receipt of this scholarship would affect you reaching that goal (must be at least 250 words): **Please attach a separate page.**

Use additional blank pages where needed to explain any answers.

MercyOne Centerville (Auxiliary/Foundation) Scholarship
References 2024

Date: _____Name of applicant:_____
Your Relationship to Applicant:_____
(Non-relative)

Please complete this reference form with your recommendation and **mail/fax/ by April 5** to:

Barbara Brown
MercyOne Centerville Medical Center
1 St. Joseph Drive
Centerville, IA 52544
Fax: 641-548-5203
Email: barbara.brown004@mercyoneiowa.org

Please rate the applicant's achievement and potential by entering an "X" in the appropriate spaces below.					
Skill	Exceptional	Above Average	Average	Below Average	No Response
Decision-making ability					
Organizational Skills					
Communication skills: • Written • Oral					
Adaptability to stress					
Positive Attitude					
Integrity					
Interpersonal Sensitivity					
Leadership ability					
Ability to commit to: • Goals • Persons					

In addition to the ratings, please give your evaluation of the applicant. It is important that you complete this section. You may want to indicate your perceptions of the applicant's strengths and limitations.

My recommendation is: ○ highly recommend ○ recommend ○ do not recommend	
Signature of Person Making Recommendation	Date
Printed Name	Business and Position (if applicable)
Address	
Primary Phone Number	Secondary Phone Number
