



WEST RIVER HEALTH SERVICES FOUNDATION

1000 Highway 12

Hettinger, ND 58639

(701) 567-6188

SCHOLARSHIP APPLICATION FOR HEALTH CARE PROFESSIONALS

1) Full Name: _____
(Last) (First) (Middle)

Social Security Number: _____

Current Mailing Address: _____
(Street) (City) (State) (Zip Code)

Telephone Number: (____) _____ E-mail address: _____

2) Permanent address and telephone number of person through whom you can be located (parent, relative, friend, etc.).

Name: _____

Address: _____
(Street) (City) (State) (Zip Code)

Telephone Number: (____) _____

3) Name of professional degree program, certification program or educational program: _____

4) Name and location of the college or university where you are enrolled: _____

5) Grade completed (end of Spring semester of current year): _____

6) Expected month and year you will complete degree requirements: _____

7) Are you enrolled as a full-time student as defined by your college or university? _____

8) Anticipated costs: Tuition _____
Fees _____
Books _____
Other _____

Total _____

9) Have you ever been employed in health related activities? Yes _____ No _____

If yes, indicate type and location of work. _____

10) Who contributes the major portion of your support? _____

Name: _____

Address: _____

Relationship: _____ Occupation: _____

11) List two references and please have your references attach a letter of recommendation to this application.

Name: _____

Address: _____

Relationship to you: _____ Professional position: _____

Name: _____

Address: _____

Relationship to you: _____ Professional position: _____

12) **Please attach a 300-word essay about yourself detailing your involvement in community, church activities, extra-curricular activities, volunteer work or over-all accomplishments.**

I hereby certify that the answers given herein are true and correct. I authorize investigation of all statements contained in this application and agree to reference checks as may be deemed necessary to verify any and all information.

Date _____ Signature _____

*Please return this application, no later than **April 1st** to:

**Bev Strand
Academic Scholarship Coordinator
West River Health Services Foundation
1000 Highway 12
Hettinger, ND 58639**

*Your file will not be considered complete until this **application** along with **current transcript, letter of acceptance** (first year college), **letter of recommendation** from references listed, and **essay** are enclosed.