

# 2010 PRE-NURSING SCHOLARSHIP CRITERIA

## SPONSOR



Marion-Polk County Medical Society

## PURPOSE

To provide assistance to a graduating senior who has selected pre-nursing as his/her academic choice.

## SCHOLARSHIP AMOUNT

\$1,500 - Funds will be awarded when the scholarship is granted.

## CRITERIA FOR SELECTION

- Applicant must be a graduating senior from a high school in the Marion or Polk Counties
- Applicant must have a 3.0 or better GPA
- Applicant must be planning to be a full-time (12 credits or more per term) student at an accredited College or University
- Applicant must complete essay question (*see application*)
- Scholarship finalists will be interviewed by the **Marion-Polk County Medical Society** Scholarship Committee
- Financial need will be considered, but this is NOT a “need-based only” scholarship.

## APPLICATION PROCESS

Applications are available at each high school in Marion and Polk Counties, online at [www.mpmedsociety.org](http://www.mpmedsociety.org) or by contacting the **Marion-Polk County Medical Society** at 503 362-9669.

- Applications and support materials must be received by the **Marion-Polk County Medical Society** no later than March 5, 2010 by 5:00 pm.
- Scholarship finalists will be notified by March 16, 2010 and interviewed shortly thereafter by the Scholarship Committee
- Scholarship recipients will be notified by April 16, 2010 and invited to attend and be recognized at the Society’s May 13, 2010 General Membership Dinner.



# Marion-Polk County Medical Society

## Pre-Nursing Scholarship Application *(type all information)*

I wish to make application for financial assistance from the **Marion-Polk County Medical Society**. I understand that scholarships are to assist worthy students from the Salem area to pursue full-time studies in medical and medically related professions. Should any money be granted to me, I agree that said money will be used to defray expenses of tuition and books

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Name of high school you currently attend: \_\_\_\_\_

School address: \_\_\_\_\_

School phone number: \_\_\_\_\_

Grade point average: \_\_\_\_\_

Colleges/universities to which you have applied:

**SCHOOL**

**ACCEPTED (Y/N)**

_____	_____
_____	_____
_____	_____
_____	_____

Father's full name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Mother's full name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

**The following information must be included with this application, and sent to the Marion-Polk County Medical Society, 698 12<sup>th</sup> St. SE #230, Salem OR 97301.**

- A. A copy of your high school academic transcript and GPA. Include your SAT/ACT scores.
- B. A short goal statement (*typed*) which describes your academic interest, career aspirations and plans. (100 words or less).
- C. A 300-500 word answer (*typed*) to the following essay question:  
  
**Why are you interested in medicine, and what impact do you hope to make in your community when you become a nurse?**
- D. Written references from your school counselor or principal, plus two other adults (preferably teachers, or employers- -not family members). References must be in by application deadline. Three references are required. (*Reference request forms are included with this application.*)

List names of individuals to whom you have sent reference request forms

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Please list your extracurricular activities (*jobs you have held, volunteer work, student clubs, etc.*)

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- I have included a financial need statement.
- I do not have a financial need statement.

I have read the preceding statements and find them to be true.

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Signature of PARENT (if applicant is a dependent) / Date

I understand that I am under obligation to return the full amount of my scholarship if I should change my course of study during the current academic year, to something other than a medical or medically related field or I am not a full-time student. Also, should I elect not to pursue my education at this time or should I terminate my schooling in this school year, I forfeit any monies awarded me. When my choice of college has been finalized, I shall notify the **Marion-Polk County Medical Society** office at (503) 362-9669.

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APPLICANT Signature / Date



## Marion-Polk County Medical Society

### Scholarship Reference Guidelines

Applicant Name: \_\_\_\_\_

Application Deadline Date: **March 5, 2010**

The above person has requested you write a reference to accompany their scholarship application. To make this easier for you as well as to facilitate the evaluation process, you may want to consider the applicant in the following areas:

- academic ability
- motivation/interest
- personal qualities
- choice of health career
- volunteer activities

The information you contribute is vital to the Scholarship Committee's review. Please address the areas that apply to you, plus any other information that might be of benefit to the committee. When finished, please forward the completed form to the above named applicant for inclusion in the scholarship packet. If you wish, to insure confidentiality, place this form in an envelope, label it with the applicant's name and sign the envelope across the seal.

Thank you for your time and assistance.

**2010 PRE-NURSING SCHOLARSHIP  
APPLICATION CHECKLIST**

*Due March 5, 2010 by 5:00 pm*

APPLICANT NAME: \_\_\_\_\_

- Completed application
- Official transcript
- SAT/ACT scores
- Goal statement
- Essay question
- References