

# Mercer County Hospital Auxiliary Scholarship Application

Name \_\_\_\_\_

Address \_\_\_\_\_

Birthdate \_\_\_\_\_ Phone \_\_\_\_\_ Spouse \_\_\_\_\_

Parents Name \_\_\_\_\_

Parents Address \_\_\_\_\_

Where Are They Employed? \_\_\_\_\_

Number of Siblings \_\_\_\_\_ Currently in College? \_\_\_\_\_

What Medical Field Do You Plan to Enter? \_\_\_\_\_

What Is Your Professional Goal? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have You Been Involved As A Volunteer, Employee, or Student Of This Profession? \_\_\_\_\_

\_\_\_\_\_

List High School and Colleges Attended And/Or Graduated From

\_\_\_\_\_

What School Do You Plan To Attend? \_\_\_\_\_

Will You Live At Home or At School? \_\_\_\_\_

List Approximate Expenses Per Academic Year:

\$ \_\_\_\_\_ Tuition \$ \_\_\_\_\_ Room \$ \_\_\_\_\_ Board \$ \_\_\_\_\_ Books

## **Mercer County Hospital Auxiliary Scholarship Application**

**List Approximate Resources Per Academic Year:**

**\$ \_\_\_\_\_ Parents \$ \_\_\_\_\_ Savings \$ \_\_\_\_\_ Loans**

**Employment While Attending School: \$ \_\_\_\_\_**

**Please Include Two Letters Of Reference Only**

**Signature \_\_\_\_\_**

**Please Return This Application By May 1<sup>st</sup>. Application Will Not Be Eligible If Postmarked Later Than May 1<sup>st</sup>.**

**Please Send Completed Application To:**

**Mercer County Hospital Auxiliary  
409 NW 9<sup>th</sup> Avenue  
Aledo, IL 61231**