



Dear Scholarship Applicant:

Applications for Schneck Foundation Allied Health Scholarships are now being accepted. Please carefully review this *informational letter* and the *Scholarship Requirements / Guidelines* to assist you in completing your **Application Packet**.

To be eligible for consideration at time of submission, your **Application Packet** must be complete and include the following items:

- Completed two-page application (*please do not print two-sided*)
- Official transcript of most-recent grades
- Proof of Acceptance to the school you plan to attend
- Two signed Letters of Recommendation
- Typed, **one-page** autobiographical letter summarizing your objectives for further education, need for assistance, and your desire to pursue a career in healthcare.

(No binders, folders, stapled, two-sided, late, or incomplete application packets will be accepted.)

This application is NOT for nursing or medical students.

Application Packet must be received in its entirety by March 15. Late or incomplete **Application Packets** will not be accepted. Submit packets to:

RETURN BY U.S. MAIL:
Schneck Foundation
411 West Tipton Street
Seymour, IN 47274

~ OR ~

PERSONALLY DROP OFF AT:
Schneck Foundation
415 S Walnut Street – Suite 201
Seymour
(No U.S. mail receptacle at this address)

To be considered candidates must apply each year for the annual Allied Health Scholarship.

Information in your Application Packet may be shared with the Schneck Medical Center Human Resources Department.

By signing and submitting the Application Packet, you grant permission and consent to release your information to media outlets (*including, but not limited to: newspapers, television, radio, journals, magazines, social media, and other print or electronic media*) and the general public.

After the Scholarship Committee has completed their review, you will be notified accordingly by letter.

If you have any questions, please feel free to contact the Foundation at (812) 524-4244 or foundation@schneckmed.org.

**SCHNECK FOUNDATION
ALLIED HEALTH SCHOLARSHIP REQUIREMENTS/GUIDELINES**

This application is NOT for nursing or medical students.

(Please see additional Scholarship info on www.schneckmed.org)

MISSION: To encourage candidates who are interested in pursuing a course of study to qualify them to work in a technical/professional career in a hospital by providing financial assistance.

GUIDELINES:

1. Primary consideration will be given to Jackson, Jennings, Scott, and Washington County residents. Residents of other counties may be considered based on available funds and at the discretion of the Scholarship Committee.
2. Careers in the following allied health/clinical support areas will be considered:
 - Certified Surgical Technologist*
 - CT Technologist*
 - Laboratory Technologist*
 - Nuclear Medicine Technologist*
 - Occupational Therapist*
 - Occupational Therapy Assistant*
 - Pharmacist*
 - Physical Therapist*
 - Physical Therapy Assistant*
 - Physician Assistant*
 - Radiologic Technologist*
 - Respiratory Technician (Certified)*
 - Respiratory Therapist (Registered)*
 - Speech-Language Pathologist*
 - Other careers may be approved by Scholarship Committee.*
3. To be considered for an award, candidate must submit completed application no later than March 15 of the current application year.
(Applications are available online at www.schneckfoundation.org, www.schneckmed.org, at the Schneck Foundation/Development Office, and through your local High School Counselor.)
4. Candidate must be accepted at a school and program of study in a technical/professional field to be eligible for an award.
5. Candidate must submit proof of acceptance to the school they plan to attend and provide their most recent transcript of grades.
6. Candidate must maintain at least a 3.5 GPA to be considered.
7. The Foundation Scholarship Committee includes members of the Schneck Foundation Board, the Schneck Hospital Administrator (or his representative), and the Schneck Vice President Workforce and Organizational Development.
8. **Scholarship award must be used for tuition only, not books, travel, housing, etc.**

To avoid disqualification, please follow directions listed in informational letter.

**SCHNECK FOUNDATION
ALLIED HEALTH SCHOLARSHIP APPLICATION
2024 – 2025 Academic Year**

For candidates interested in pursuing a course of study in a Technical/Professional career in healthcare.
(Information submitted may be shared with Schneck Medical Center Human Resources.)

PERSONAL INFORMATION:

NAME: _____
(First) (Middle Initial) (Last)

HOME ADDRESS: _____
(Street)

(City) (State) (Zip) Phone: (____) _____ - _____

E-mail: _____

Age: ____ Sex: ____ County of Residence: _____

Father's Name: _____ Occupation: _____

Father's Address: _____

Mother's Name: _____ Occupation: _____

Mother's Address: _____

Number and ages of siblings (indicate if in college): _____

Marital Status: _____ if married, spouse's name: _____

Occupation of Spouse: _____ No. Children: _____ Ages: _____

EDUCATIONAL BACKGROUND

High School	Location	Year Graduated	Diploma Type
_____	_____	_____	_____
List of School(s) Attended	Location	Years	Major/Course of Study
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

College/School where you have been accepted/are enrolled: _____

Allied healthcare program in which you are enrolled or declared major: _____

Anticipated degree: _____

Anticipated date of graduation: Undergraduate: _____

Graduate/Professional: _____

Career objectives: _____

EXTRACURRICULAR ACTIVITIES

Please list organizations, clubs, and athletics you have been involved with, including years of involvement and leadership positions held:

Honors and awards you have received:

Community Activities:

EMPLOYMENT HISTORY (PAST AND PRESENT)

Job Title/Description	Hours Worked/Wk	Period of Employment
_____	_____	_____ to _____
_____	_____	_____ to _____
_____	_____	_____ to _____

- I am a current Schneck employee. If yes, Department: _____
- I am a current Schneck employee tuition assistance participant
- I have been a Schneck Junior Volunteer. If yes, year(s): _____
- I have previously worked at Schneck Medical Center. If yes, please give specifics: _____

FINANCIAL RESOURCES

Estimated annual cost of attending school: \$ _____

Estimated parent contribution: \$ _____

Estimated student contribution: \$ _____

List of current scholarships, grants, and funds:

_____	\$ _____
_____	\$ _____
_____	\$ _____

Existing educational loan balances:

_____ \$ _____

Other financial considerations: _____

I certify that the information on this application is true and accurate to the best of my knowledge. I understand that information contained in this application and its supporting documents becomes property of Schneck Medical Center.

(Applicant's Signature)

(Date)