



Dear Scholarship Applicant:

Applications for the Amanda M. Dick Honorary Scholarship 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 medical 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 the medical field

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

**Application Packets** 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 at Laurel Place  
415 S Walnut Street – Suite 201  
Seymour  
*(No U.S. mail receptacle at this address)*

The Amanda M. Dick Honorary Scholarship is awarded to one recipient annually. To be considered, candidates must apply each year.

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

By signing below, I hereby grant Schneck Medical Center the right to distribute and/or publish my name for medical, scientific, educational, advertising, publicity, commercial, philanthropic and/or other reasonable and legitimate business purposes.

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](mailto:foundation@schneckmed.org).

**AMANDA M. DICK HONORARY SCHOLARSHIP  
REQUIREMENTS/GUIDELINES**

MISSION: To support female candidates who are pursuing a career in the medical field and are currently accepted into medical school.

GUIDELINES:

1. Applicant must be a female student currently accepted into medical school.
2. 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.
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](http://www.schneckfoundation.org) or [www.schneckmed.org](http://www.schneckmed.org).)*
4. Candidate must submit proof of acceptance into the medical school they plan to attend and provide their most-recent transcript of grades.
5. The Foundation Scholarship Committee includes members of the Schneck Foundation Board, the Schneck Hospital Administrator (or his representative), and the Schneck Vice-President of Workforce and Organizational Development.
6. Scholarship award must be used for tuition only, not books, travel, housing, etc.
7. Awards will be paid directly to the medical school.

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

# AMANDA M. DICK HONORARY SCHOLARSHIP APPLICATION

## 2024 – 2025 Academic Year

*(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 Attended	Major/Degree
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical school where you have been accepted: \_\_\_\_\_

Anticipated degree:  M.D.  D.O.  Other: \_\_\_\_\_

Anticipated date of graduation: \_\_\_\_\_

Area of interest: \_\_\_\_\_

Career objectives: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**EXTRACURRICULAR ACTIVITIES**

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

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Honors and awards you have received:

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Community Activities:

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**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 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)