

Van Diest Medical Center Auxiliary Scholarship Application

Name _____ Year Graduated: High School _____ College _____
 Current address _____ City _____ State _____ Zip _____
 Phone number _____ Email _____
 Parents _____ Occupation _____
 Number of siblings in the family _____
 College choice _____ Major _____
 College address _____ State _____ Zip _____
 What is the yearly tuition of this college? _____
 Have you applied? _____ If so, have you been accepted? _____
 Have you applied for or are receiving any other financial aid? _____ If yes, what is the amount? _____
 And, which of these is it: Grant _____ Loan _____ Scholarship _____

Program Type

Indicate the program in which you are enrolled or to which you have been accepted.

Please note education must be completed in 4 years.

- | | |
|---|---|
| <input type="checkbox"/> Clinical Lab Scientist/Medical Technologist | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Clinical Lab Technician/Medical Lab Technician | <input type="checkbox"/> Physical Therapist Assistant |
| <input type="checkbox"/> Dentistry or Orthodontics | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Medical Assistant | <input type="checkbox"/> Psychologist/Therapist |
| <input type="checkbox"/> Nursing (RN) | <input type="checkbox"/> Pre-Medicine |
| <input type="checkbox"/> Nursing (BSN) | <input type="checkbox"/> Radiation Therapist |
| <input type="checkbox"/> Nursing (Masters – MSN) | <input type="checkbox"/> Respiratory Therapist |
| <input type="checkbox"/> Nurse Practitioner (NP) | <input type="checkbox"/> Social Worker (LISW) |
| <input type="checkbox"/> Doctor of Nursing (DNP) | <input type="checkbox"/> Speech Pathologist |
| <input type="checkbox"/> Kinesiology and Health | <input type="checkbox"/> Surgery Technician |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Ultrasound Technologist |
| <input type="checkbox"/> Occupational Therapist Assistant | <input type="checkbox"/> EMT/Paramedic |
| <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Other: _____ |

Two (2) written references **must accompany** this application by a non-relative:

1. _____
2. _____

(If recipient is unable to attend school, the award would revert to the Auxiliary to be given to an alternate. You will notify as per #8 on the attached sheet.)

*Include a short paragraph stating why you have chosen a career in the medical field, and if you are currently employed part-time or full-time and where. You may use the back of this application form.

I hereby promise that the above information is true and not falsified to the best of my knowledge.

Signature _____

Please send completed application by April 15, 2025, or postmarked no later than April 15, 2025 to:

Lorraine Habben, 1515 Sparboe Ct., Webster City, IA 50595 515-832-1357

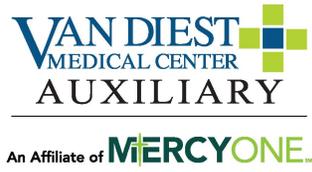
VAN DIEST MEDICAL CENTER AUXILIARY SCHOLARSHIP

AWARD: Shall be \$1,000.00 payable at registration for the Fall semester, to be paid by check jointly to the student and college.

1. The Award shall be granted to a high school graduate who wishes to pursue a career in the medical field. Persons going back to further their education in the medical field will also be considered. You must be a resident of Hamilton County or a graduate of any Hamilton County High School at the time of the award or you must work or have a parent working for Van Diest Medical Center.
2. The recipient shall enroll in an approved healthcare career program* at an accredited school and complete education within 4 years.
3. The Award shall be used for tuition, fees, books, or board and room.
4. Two (2) written character references from non-relatives are required.
5. The Award Committee shall consist of three (3) members of the Van Diest Medical Center Auxiliary.
6. Interested students may apply for consideration for this scholarship by completing the application. **Deadline for the application is April 15, 2025 or postmarked no later than April 15, 2025.**
7. It is our policy to give only one scholarship to each person. **Please do not apply if you received a scholarship from us in the past.**
8. If the recipient is unable to attend school, the Award should revert to the Auxiliary to be given to an alternate. The Auxiliary should be notified by the student or other person who is responsible in assisting them.

*** Approved healthcare programs**

| | |
|--|------------------------------|
| Clinical Lab Scientist/Medical Technologist | Pharmacist |
| Clinical Lab Technician/Medical Lab Technician | Physical Therapist |
| Dentistry or Orthodontics | Physical Therapist Assistant |
| Medical Assistant | Radiation Therapist |
| Nursing (RN) | Physician Assistant |
| Nursing (BSN) | Psychologist/Therapist |
| Nursing (Masters – MSN) | Respiratory Therapist |
| Nurse Practitioner (NP) | Social Worker (LISW) |
| Doctor of Nursing (DNP) | Speech Pathologist |
| Pre-Medicine | Surgery Technician |
| Kinesiology and Health | Ultrasound Technologist |
| Occupational Therapist | EMT/Paramedic |
| Occupational Therapist Assistant | |



Van Diest Medical Center Auxiliary Scholarships

Number of Scholarships: Six (6)

Amount of Scholarships: \$1,000 each

Who Qualifies: 2025 high school graduates **OR** those returning to further their education in the medical field.

INQUIRE at the Counselor's Office for a form and information regarding this application.

DEADLINE for the application form is **APRIL 15, 2025** or post-marked no later than **APRIL 15, 2025**.

Applicants must be a resident of Hamilton County or a graduate of any Hamilton County high school, work or have a parent working at Van Diest Medical Center at the time of the award.