NOTE: The Clarke County Hospital (CCH) Auxiliary Healthcare Career Scholarship program is open to residents attending a Clarke County school or persons who work in a medically related field in Clarke County. Typically, the Auxiliary awards 4 scholarships per year. The program is a competitive process and all eligible applications may not receive funding. Incomplete applications will not be considered.

Recipients are asked to make an appearance at the Auxiliary Golf Tournament. This year’s tournament is July 11, 2025.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please type or print.** | | | | | | | | | |
| **PROGRAM TYPE** | | | | | | | | | |
| *Indicate the program in which you are enrolled or to which you have been accepted.* | | | | | | | | | |
| * Clinical Laboratory Scientist/ | * Nursing (LPN) | |  |  | * Physical Therapist Assistant | | | | |
| Medical Technologist | * Nursing Assistant | | |  | * Registered Radiological Technologist | | | | |
| * Clinical Laboratory Technician/ | * Occupational Therapist | | |  | Discipline | | | | |
| Medical Lab Technician | * Pharmacist |  |  |  | * Respiratory Therapist | | | | |
| * Nurse Anesthetist | * Pharmacy Technician | | |  | * Surgery Technician | | | |  |
| * Nursing (RN) | * Physical Therapist | | |  | * Ultrasound Technologist | | | | |
|  |  | | |  | * Other: | | | | |
| **APPLICANT INFORMATION** | | | | | | | | | |
| Name: (Last, First, Middle Initial) | | | | | | | | | |
| Maiden Name/Other Names Used | | | | | Telephone #( ) | | | | |
| Current Mailing Address (Street, Apt #) | | | City | | | | State | Zip | |
| E-mail Address: | | | | | | | | | |
| Permanent Mailing Address (Street, Apt #) | | | City | | | | State | Zip | |
| Where do you want scholarship correspondence sent *(check all that apply*)?  E-mail  Current Address  Permanent Address | | | | | | | | | |
| **EDUCATION** | | | | | | | | | |
| College/University of the program in which you are enrolled or to which you have been accepted: | | | | | | | | | |
| Circle the highest grade completed. 1 2 3 4 5 6 7 8 9 10 11 12 GED College: 1 2 3 4 | | | | | | | | | |
| High School Attended and Location: | | | | | | Graduation Date: | | | |
| College/University Attended and Location | | Dates Attended: | | Hours | | Graduation Date: | | | Degree Earned: |
| College/University Attended and Location | | Dates Attended: | | Hours | | Graduation Date: | | | Degree Earned: |
| College/University Attended and Location | | Dates Attended: | | Hours | | Graduation Date: | | | Degree Earned: |
| **If additional space is needed, please attach a separate sheet.** | | | | | | | | | |

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| **ENROLLMENT** | | | | | | | | | | | | | | |
| Name of Institution: | | | | Address (Street, City, State, Zip): | | | | | | | | | | |
| Name of Contact Person: | | Title of Contact Person: | | | | | | | | Telephone: ( ) | | | | |
| Academic Year Applied For: | Student’s Current Year in the Program: | | | | | | | Program Start Date: | | | | | Projected Graduation Date: | |
| **CLOSEST LIVING RELATIVE** | | | | | | | | | | | | | | |
| Name (Last, First, Middle Initial): | | | Relationship: | | | | | | | Telephone: ( ) | | | | |
| Street, Apt. # | | | | | City | | | | | | State | | | Zip |
| **EMPLOYMENT** | | | | | | | | | | | | | | |
| Are you currently employed?  Yes  No | Start Date | | | | | May we contact you at work?   * Yes  No | | | | | | Work Telephone: ( ) | | |
| If yes, name and address of employer | | | | | | | | | Do you plan to remain with this employer?  Yes  No | | | | | |
| **PERSONAL STATEMENT AND ADDITIONAL INFORMATION** | | | | | | | | | | | | | | |
| Please attach a typewritten personal narrative, not to exceed 300 words, about why you chose the health related field you are entering, your career goals, an explanation of why you need the scholarship, and any extra ordinary factors, which should be considered by the committee. | | | | | | | | | | | | | | |
| Submit transcript from current academic year, extracurricular, community or healthcare activities. Indicate the scope of each activity and your level of participation. | | | | | | | | | | | | | | |
| **APPLICANT** | | | | | | | | | | | | | | |
| ***Mail the original completed application to Clarke County Hospital Auxiliary Scholarship, Marjorie Wambold, 125 E. Washington St, Apt 13, Osceola, IA 50213.*** *Questions regarding the application and selection process should be directed to Dwan Wyles at 641-342-5489 or* [*dwyles@clarkehosp.org..*](mailto:dwyles@clarkehosp.org..)  *If you would change your intentions to pursue a medically related field, please notify the Clarke County Auxiliary Scholarship Chairperson immediately. For undergrads, the scholarship will be issued in 2 payments ($750) for each semester). For continuing education students, the payment will be issued as approved by the Auxiliary Board of Directors.* | | | | | | | | | | | | | | |
| Signature of Applicant: | | | | | | | Date: | | | | | | | |