



William G. and Ruth T. Evans Endowed Nursing Scholarship Application

**Incomplete applications will not be considered. If you have questions,
call the Ashland Community Hospital Foundation at (541) 201-4014**

I. PERSONAL INFORMATION	
Full Name:	
Permanent Address:	City: State: Zip:
Local Address : (if different from permanent)	City: State: Zip:
Phone Number: ()	Email:
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth:	
Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide verification of your status according to the U.S. Naturalization and Immigration Service.	
What is the total number of people living in your household, including yourself?	
II. ENROLLMENT INFORMATION	
<ul style="list-style-type: none"> ▪ Provide the name and address of the college/university into which you have been accepted or are presently enrolled. 	
Name of School:	
Address:	City: State: Zip:
Degree you are seeking:	
Date you began/will begin this curriculum (month/year):	
Date you will graduate (month/year):	
III. EDUCATION	
<ul style="list-style-type: none"> ▪ Please complete the following information about your college and graduate education. Attach official transcripts of the courses you have taken from each of the schools you have attended. 	
Name of School:	
Address:	City: State: Zip:
Dates attended (month/year):	
Major or Degree:	
Scholastic Honors:	
Total number of hours completed:	Cumulative G.P.A.:
Transcripts attached: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, explain why:

Name of School:	
Address:	City: State: Zip:
Dates attended (month/year):	
Major or Degree:	
Scholastic Honors:	
Total number of hours completed:	Cumulative G.P.A.:
Transcripts attached: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, explain why:
Name of School:	
Address:	City: State: Zip:
Dates attended (month/year):	
Major or Degree:	
Scholastic Honors:	
Total number of hours completed:	Cumulative G.P.A.:
Transcripts attached: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, explain why:
Name of School:	
Address:	City: State: Zip:
Dates attended (month/year):	
Major or Degree:	
Scholastic Honors:	
Total number of hours completed:	Cumulative G.P.A.:
Transcripts attached: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, explain why:
IV. PERSONAL ESSAY	
<ul style="list-style-type: none"> ▪ Please submit with this application a narrative of 250 words in which you describe why you are pursuing the degree you've chosen and your career plans upon achieving your degree. 	
V. WORK OR VOLUNTEER EXPERIENCE	
Name of Employer/ Organization:	Phone Number ()
Address:	City: State: Zip:
Dates of Employment/Service (month/year):	Supervisor's Name:
Position Title:	
Duties :	
Average Hours Worked (per week):	Rate of Pay:

Name of Employer/ Organization:	Phone Number ()
Address:	City: State: Zip:
Dates of Employment/Service (month/year):	Supervisor's Name:
Position Title:	
Duties :	
Average Hours Worked (per week):	Rate of Pay:
Name of Employer/ Organization:	Phone Number ()
Address:	City: State: Zip:
Dates of Employment/Service (month/year):	Supervisor's Name:
Position Title:	
Duties :	
Average Hours Worked (per week):	Rate of Pay:
Name of Employer/ Organization:	Phone Number ()
Address:	City: State: Zip:
Dates of Employment/Service (month/year):	Supervisor's Name:
Position Title:	
Duties :	
Average Hours Worked (per week):	Rate of Pay:
VI. REFERENCES	
<ul style="list-style-type: none"> ▪ Please submit two letters of reference from people who are not relatives and have known you for at least one year. One letter must be from a current or past instructor. 	
VII. FINANCIAL INFORMATION	
<ul style="list-style-type: none"> ▪ Include a copy of your financial aid award letter from your college/university. 	
1. What was your personal income for the last calendar year as reported on your W-2 form(s) or Income Tax Return: or your family income:	
2. Answer the following question, providing information which corresponds to your present situation: What was the adjusted gross income for last calendar year of:	
<input type="checkbox"/> Your parent(s) or guardian(s) if you are a dependent, or <input type="checkbox"/> Your household if you are living independently <u>and</u> if the amount is different from item 1	
\$ _____	
3. Where will you live while attending college during the academic year?	
<input type="checkbox"/> On campus housing (residence hall, etc.) <input type="checkbox"/> Off campus housing (apartment, etc.) <input type="checkbox"/> At home with parent(s), guardian (s), or spouse	<input type="checkbox"/> Independently <input type="checkbox"/> Other: _____

Prior financial assistance: 4. If you attended college for the prior academic year, list all financial assistance (grants, scholarships, loans, etc.) received, including amounts:	
	\$
	\$
	\$
	\$
Expected financial assistance: 5. List all financial assistance (grants, scholarships, loans, etc.) you have been notified of or expect to receive for the next academic year, including amounts:	
	\$
	\$
	\$
	\$
VIII. SCHOOL YEAR EMPLOYMENT	
If you will work while attending college please indicate:	
Number of hours you expect to work per week: _____	
Your estimated annual income from this job: \$ _____	
IX. FUTURE EMPLOYMENT	
Where do you plan to work as a nurse? <input type="checkbox"/> Rogue Valley <input type="checkbox"/> Oregon <input type="checkbox"/> Outside of Oregon	
X. PERSONAL COMMENT:	
<ul style="list-style-type: none"> Is there any information or other comments you would like to add to this application? (You may continue on the back of this page, if needed) 	
XI. YOUR SIGNATURE:	
I hereby apply for an Ashland Community Hospital Foundation Scholarship. I have read and understand the terms of the scholarship award. I understand that a scholarship award is dependent upon my acceptance into the nursing program.	
_____	_____
Signature	Date

Return this application along with all other information requested to:
 Ashland Community Hospital Foundation, P.O. Box 98, Ashland, OR 97520
 Phone: 541.201.4014 Fax: 541.488.7516