ACRMC Auxiliary Scholarship Application

Criteria: Applicant must be a resident of Adams or Brown County or an employee of ACRMC. Applicant must be enrolled in a regionally accredited institution of higher education pursuing a career in a health care profession. The \$1,000 scholarship award will be made payable to the scholarship awardee upon proof of completion of first semester or quarter, which begins after May 30, 2025. Applications must be returned to the ACRMC Auxiliary, P.O. Box 233, Seaman, Ohio 45679 and postmarked by April 1, 2025 deadline. Scholarship awardees will be announced prior to June 30, 2025.

Applicant Personal Inform	ation:		
Last Name:	First Name:		M.I.:
Phone:	Email:		
Street Address:		County:	
City:	State:	Zip Code:	
Academic: Provide a copy o	f your latest transcript, including	your current GP.	A and any ACT or SAT scores.
I have been accepted at			College/University
(Provide a copy of acceptance			Conege/Oniversity
(Provide a copy of your letter	thcare Program:NoYes F of healthcare program acceptant	ce.)	
College Status:Freshman	SophomoreJuniorSen	iorMaster _	Other:
and contact name and phone related employment, include Healthcare Experience: Prohours you have completed. Tresponsibilities and the numb	_	dates. If your empations and/or lices theare job shadow opriate superviso	ployment includes healthcare nses. wing, clinical hours, practicum or, include a description of your
completed in the last 12 mon number of the person who car	Activities: Provide a list of schools only, including number of how a verify your involvement.	ars volunteered a	unity activities you have along with the name and contact
	e a one page statement about you lated scholarship along with a st		
Supporting Documentation guidance counselor, professor	Provide at least two letters of re, community leader, or employer	commendation fir, who is not rela	rom: a current supervisor, ted to you.
am awarded a scholarship, I a	release of all information to the gree to abide by all conditions of information in publicity materia	f the scholarship	ary Scholarship Committee. If I and I give permission to the
Signature:		Date:	

ACRMC Auxiliary does not discriminate against applicants on the basis of race, color, religion, age, sex, marital status, veteran status, national origin, ancestry, citizenship, gender identity, sexual orientation, or disability. Rev: 1/2023, 4/23, 1/25

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Last Name:	Applicant Personal Information	on:			
Street Address:	Last Name:	First Name:		M.I.:	
Street Address:	Phone:	Email:			
City:					
I have been accepted at					
Are you accepted into a Healthcare Program:NoYes Program Title	Academic: Provide a copy of yo	our latest transcript, including	g your current G	PA and any ACT or SAT scores.	
(Provide a copy of your letter of healthcare program acceptance.) College Status:FreshmanSophomoreJuniorSeniorMasterOther: Employment History: Provide a list of current and previous employers. Include name of employer, address, and contact name and phone number along with employment dates. If your employment includes healthcare related employment, include a copy of any healthcare certifications and/or licenses. Healthcare Experience: Provide a letter describing any healthcare job shadowing, clinical hours, practicum hours you have completed. The letter must be signed by appropriate supervisor, include a description of your responsibilities and the number of hours completed. School/Community Service Activities: Provide a list of school and/or community activities you have completed in the last 12 months only, including number of hours volunteered along with the name and contact number of the person who can verify your involvement. Personal Statement: Provide a one page statement about your background and how it is pertinent to your application for a healthcare related scholarship along with a statement about your career goals in healthcare. Supporting Documentation: Provide at least two letters of recommendation from: a current supervisor, guidance counselor, professor, community leader, or employer, who is not related to you. Certification: I authorize the release of all information to the ACRMC Auxiliary Scholarship Committee. If am awarded a scholarship, I agree to abide by all conditions of the scholarship and I give permission to the ACRMC Auxiliary to use my information in publicity materials.	I have been accepted at(Provide a copy of acceptance le	tter.)		College/University	
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Signature: Date:	am awarded a scholarship, I agre	e to abide by all conditions o	f the scholarshi	liary Scholarship Committee. If I p and I give permission to the	
	Signature:		Date:		

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