



Date: January 20, 2025

To: High School Seniors of  
Adams, Brown and Clermont Counties

From: Samir Ataya, M.D., Chief of Staff

On behalf of the Medical Staff of Mercy Health - Clermont Hospital, I am proud to invite you to apply for the **Mercy Clermont Physicians' Scholarship Award**. This is the 20<sup>th</sup> year of the award which is supported by the funds of the Medical Staff of the hospital. Eligible students are those completing their senior year of high school at a school located in Adams, Brown or Clermont County, and who are preparing to graduate and attend college to pursue a career in a healthcare-related field.

The Medical Staff strongly supports the community surrounding the hospital and extends this action to the youth of the community who will in the future be supporting the community.

We are encouraging financially and academically deserving individuals who meet the criteria to apply for this scholarship opportunity. An application form is enclosed.

The criteria for the application are detailed on the application form. Complete applications must be returned by **March 14, 2025** to be considered.

If you have any questions, please contact Mindy Hays in the Medical Staff Services Office, at [mhays@mercy.com](mailto:mhays@mercy.com) or at (513) 732-8327.

Thank you very much.

**NOTE:** Award recipients are requested to keep the Medical Staff informed of their progress towards their healthcare career goals, including confirmation of their college graduation and ultimate employment in the healthcare field.

# Mercy Health – Clermont Hospital Physicians’ Scholarship Awards 2025

## *Application Checklist*

- **Only complete applications will be considered.**
- **Please submit this form with your application to ensure your application is complete.**

Applicant Name: _____		
	<b>Required Items</b>	<b>Included Y/N</b>
1.	Application – all sections complete and legible	
2.	Signature: Guidance Counselor/Principal	
3.	Letter(s) of Recommendation	
4.	Letter(s) of Reference from Guidance/Principal/Teacher	
5.	Signature: Parental Financial Need Endorsement/Testimonial	
6.	Transcript of High School Grades	
7.	Transcript of SAT/ACT scores (Can be included with HS Grades)	
8.	Personal Composition (Essay)	
Comments: _____ _____ _____ _____ _____		

# PHYSICIANS' CHARITABLE FOUNDATION 2025 SCHOLARSHIP APPLICATION

**DEADLINE FOR SUBMISSION: March 14, 2025**

PLEASE RETURN FORM TO:

MEDICAL STAFF OFFICE  
MERCY HEALTH-CLERMONT HOSPITAL  
3000 HOSPITAL DRIVE  
BATAVIA, OHIO 45103

## **Requirements to Complete this Application:**

1. Completed application form including Personal Mission Statement
2. Personal letter of recommendation (cannot be a family member)
3. Letter of reference to support your community service interests and/or achievements
4. High school counselor or principal's signature on application
5. Parental financial need endorsement and testimonial
6. Transcript of high school grades including SAT or ACT scores
7. Applicant's parent cannot be a physician or surgeon
8. Pursuing a career in the medical field (ie, nursing, pre-med, physician assistant, rad tech, PT/OT, etc.)
9. Application Checklist – please complete and return with application

**NOTE:** Awardees are requested to keep the Medical Staff informed of their progress towards their healthcare career goals, including confirmation of their college graduation and ultimate employment in the healthcare field.

## **1. Personal Information – please legibly print all information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ SSN#: \_\_\_\_\_ e-mail: \_\_\_\_\_

High School: \_\_\_\_\_

High School Guidance Counselor: \_\_\_\_\_

High School Activities (Student Council/Government, Teams, Clubs, Honors, etc.) (attach additional sheet if necessary):

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Community Interests / Achievements / Volunteer Work or Paid Employment (attach additional sheet if necessary):

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Health-related Science Career Goals or Interests:

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**Personal Mission Statement – Vision – Goals – Make a Difference**

Please accompany this application with a personal essay limited to 250 words featuring something about yourself and your interests, what you may have gained/given in your community service experiences and how this scholarship will help you to achieve future health care career goals, and any additional pertinent information.

**2. Personal Reference** (letters should be submitted separately)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

**3. Community Service and/or Achievement Reference** (letter should be submitted separately)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

#### **4. Guidance Counselor or Principal's Endorsement**

I support the application of \_\_\_\_\_ for the Physicians' Charitable Foundation Scholarship and certify that he/she has attained a grade point average of \_\_\_\_\_ for grades 10, 11, and 12 for 3-year high school, or grades 9, 10, 11, 12 for a 4-year high school, through 12/31/24.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

#### **5. Financial Statement and Affidavit**

I / We understand as the parent(s) / guardians of \_\_\_\_\_ that the Physicians' Charitable Foundation Scholarship is awarded, in part, based on financial need and accordingly attest in good conscience that our son / daughter is financially deserving of consideration for this scholarship award. (Parents may attach a separate confidential, optional, description of special factors delineating need for financial assistance for their child if desired. This statement could summarize the family's obligations and resources. This statement can be mailed, separately, if desired to the Physicians' Charitable Foundation, Medical Staff Office, Mercy Hospital Clermont, 3000 Hospital Drive, Batavia, Ohio 45103. By signing this form I/we attest that all information in this application and all attachments are a true and accurate record.

Parental

Signature(s): \_\_\_\_\_ Date: \_\_\_\_\_

Printed

Name(s): \_\_\_\_\_

Home Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

#### **Affiliation with Mercy Clermont**

Special Consideration is given to employees and volunteers of Mercy Hospital Clermont and their dependents. If you or a relative are an employee or volunteer, please give the name and position of that individual.

Name: \_\_\_\_\_

Position: \_\_\_\_\_