CHAMBERSBURG AREA HOSPITAL AUXILIARY
$1000 SCHOLARSHIP FOR AN ADULT

1. Student must live within the area that the Chambersburg Hospital serves.

2. Student must enter Human Health Related Field and must start classes within the year.

3. Student must complete application.

4. Student will receive the award for one year only.

5. The Award will be given in one lump sum.

6. Application must be post marked on or before April 15, 2020.

7. Three letters of recommendation must accompany application - one personal and two professionals.

8. Please enclose a current transcript.

9. Send application to:

   Jacqui Wolfe
   Chambersburg Area Hospital Auxiliary Scholarship Committee
   527 Larkspur Lane
   Chambersburg, PA 17202
1000 SCHOLARSHIP AWARD
APPLICATION FOR ADULT STUDENT ENTERING HUMAN HEALTH FIELD

NAME __________________________    DATE OF BIRTH _________________

ADDRESS _______________________  HIGH SCHOOL ___________________

_________________________________  YEAR GRADUATED __________

TELEPHONE _____________________  COLLEGE ____________________

E-MAIL ADDRESS: ____________________        YEAR GRADUATED __________

1. What field of Human Health Care do you plan to enter?

2. List schools where you have applied for admission in the human health field.

3. Have you been accepted? Yes □ No □
   Name the school you plan to attend. _____________________

4. Single □ Married □
   Parent’s Address: Spouse’s Address
   ____________________________________________
   ____________________________________________
   ____________________________________________

5. Your Occupation ________________    Spouse’s Occupation ________________

6. Number of children __________
   A. Their Ages __________
   B. Number self-supporting: Totally ________ Partially ______
   C. Number in College, training school, or any schools other than elementary or Secondary, [middle, junior/senior high] schools.

7. Describe any employment you have had and list any community service and hours.
8. Write an explanation why this Scholarship Award is needed and why you have chosen this field.

9. Statement of Financial Need by Applicant. **This information will be considered confidential by the Committee.**

   I certify that financial assistance is necessary for the applicant to enter and complete this Human Health Care Field.

   1. Your present Employment _______________ Annual Income __________

   2. Spouse’s Employment ________________ Annual Income __________

   3. Parent’s Employment ________________ Annual Income __________

   4. Rent Home ☐ Own Home ☐

   5. List financial obligations.

   6. Circumstances limiting your earning ability.

   __________________________________________
   Signature