REQUIRED ATTACHMENTS:

Omission of any of the following will eliminate your application from consideration. Because we receive numerous applications, we cannot match items sent in separately. We cannot use online databases to look up transcripts. You are responsible for obtaining, packaging, and delivering all required items together or risk being disqualified from consideration.

1. An official copy or signed copy of high school transcript and/or higher education transcript(s) if applicable. ***This requirement may be waived for non-traditional students (those who are not currently in school or have not attended any school in the past 3 years or more.) Please contact us to verify.***

2. A letter (one page maximum) describing your reasons for selecting a specific health career, career goals, how you hope to use your degree in the future, the need for financial assistance, and any other information you would like considered as a part of the application. ***This will weigh heavily in your selection as a recipient.***

3. Two (2) written recommendations from your instructors, employers, community leaders and/or clergy who are unrelated and able to comment on your abilities, character, personality and commitment to education and health care. See page four of the application.

4. A copy of your latest submittal of the *Free Application for Federal Student Aid* (FAFSA) which can be obtained online at **https://studentaid.gov/.** Be sure to include the ***entire form*** (generally 7-8 pages).

SUBMISSION: Must be received by April 15, 2025

Mail or hand delivery: Joanna Wiley, Scholarship Coordinator
Mon Health Medical Center Foundation
1200 J.D. Anderson Drive
Morgantown, WV 26505

- Package application and attachments together in one large, flat envelope.
- Please *do not* staple items together.
- Please *do not* submit two-sided copies.

Email: Joanna.Wiley@VandaliaHealth.org

- You may email your application and all required attachments together in ***one*** scanned PDF file.

QUESTIONS: Joanna.Wiley@VandaliaHealth.org; 304-598-1243

2025/26 Application
Mon Health Medical Center Health Career Scholarship

Revised Jan 25

Please print or type all information clearly.

DATE: _____

Please choose one:

☐ I am graduating from high school in Spring 2025 and will attend higher education school in Fall 2025.

☐ I am currently attending higher education school and will be attending in Fall 2025.

☐ I am a non-traditional student planning to attend school in Fall 2025. (Not currently attending any school or have not been in school for past 3 years or more.)

PERSONAL DATA:

NAME: _____

MAILING ADDRESS: _____

_____

City State Zip County

CELL PHONE (preferred) or HOME PHONE: _____

EMAIL: _____

EDUCATION:

HIGH SCHOOL: _____

Year Graduated Name of School

Guidance Counselor (high school seniors only): _____

OTHER SCHOOLING: _____

_____

COMPOSITE ACT and/or SAT: _____ GPA: _____

PLANNED ENROLLMENT:

NAME OF CURRENT OR EXPECTED HIGHER EDUCATION SCHOOL:

_____

CURRENT or EXPECTED STATUS: ☐ Full Time ☐ Part Time (Min. of 6 hrs per semester)

CURRENT or EXPECTED PROGRAM OF STUDY: _____

EXPECTED GRADUATION DATE: _____
(From Higher Education School)

EMPLOYMENT DATA:

HEALTH CAREER EMPLOYMENT AND/OR VOLUNTEER EXPERIENCE: _____

_____

_____

CURRENT OCCUPATION: _____

DO YOU WORK OR VOLUNTEER FOR MON HEALTH SYSTEM?

☐ Work ☐ Volunteer ☐ No If yes, list facility, department(s), and dates:

_____

DOES EITHER PARENT WORK OR VOLUNTEER FOR MON HEALTH SYSTEM?

☐ Work ☐ Volunteer ☐ No If yes, list name, facility, and department:

_____

FAMILY & FINANCIAL STATUS:

Choose one and complete applicable information:

☐ SINGLE, DEPENDENT (listed as dependent by parents)

Parents combined annual income: _____

Number of dependents including applicant: _____

Ages of dependents including applicant: _____

SINGLE, INDEPENDENT Your current annual income: _____

MARRIED (Combined household income): _____
Total income of you and your spouse

Number/Ages of dependents: _____

HAVE YOU APPLIED FOR THE PROMISE SCHOLARSHIP? ☐ YES ☐ NO

List all other scholarships, grants, educational or personal loans, tuition waivers or other financial assistance requested (you may provide as an attachment). You may not accept more aid from all sources than exceeds your annual tuition, room and board, books and lab fees. Please specify type and amounts:

NAME	STATUS		
	Approved	Pending	Rejected
1. _____	☐	☐	☐
2. _____	☐	☐	☐
3. _____	☐	☐	☐

CONSENT TO RELEASE INFORMATION

I (we) hereby consent to the release of information from any of the above to the Mon Health Medical Center Foundation.

I hereby certify that the information set forth in this application is true and complete to the best of my knowledge. Further, I hereby give my permission for The Mon Health Medical Center Foundation or its designated representatives to contact my Financial Aid Officer, Guidance Counselor, or other Advisor at my school in which I am enrolled, have been previously enrolled, or to which I have made application. This contract shall be for the purpose of soliciting and obtaining information which may be necessary or helpful to The Foundation in understanding my academic career and financial needs in connection with the processing of this application or for the purpose of auditing the use of scholarship funds received because of application made to The Mon Health Medical Center Foundation Scholarship Program.

Signature: _____ Date: _____
Applicant

If applicant if listed as dependent on 2024 Federal Tax Return, then a parent or legal guardian must also sign:

Signature: _____ Date: _____
Parent/legal guardian

Mon Health Medical Center Foundation

Letter of Recommendation - Health Career Scholarship

Complete items one and two below before forwarding the form to the respondent.

1. APPLICANT'S FULL NAME: _____

The Foundation requires two letters of recommendation from individuals who may provide pertinent information regarding your candidacy as a recipient of an award. Deliver this form to individuals who know you well enough to provide information requested. Include your signature on the line below if you wish to waive your rights under the Family Education Rights and Privacy Act of 1974.

2. WAIVER BY APPLICANT

I have asked: _____ and: _____
to provide letters of recommendation. I understand my rights under the Family Educational Rights and Privacy Act of 1974 to examine letters received by you on my behalf. To encourage the author to write with candor, I waive the right of access under the aforesaid statute to any confidential statement the writer may submit. I understand the execution of the waiver is not a condition for the consideration of my application.

_____ _____

Applicant's Signature Date

****

Dear Respondent:

The above-named person is applying for a scholarship through The Mon Health Medical Center Foundation Scholarship Program. As a part of that procedure, the applicant is required to have two (2) letters of recommendation returned to The Foundation as part of a total application package. **You may put your response in a sealed envelope with the applicant's name on it and return to the applicant to be submitted with his/her application, which is due in the office of The Foundation by April 15, 2025.**

Your information will assist The Foundation in making important decisions. Please give us the benefit of your observations of the applicant based upon personal knowledge. Unless the rights afforded by the Family Educational Rights and Privacy Act of 1974 are waived by the applicant by the execution of the waiver above, The Foundation cannot assure the confidentiality of your comments.