



TRI-STATE MEMORIAL HOSPITAL AUXILIARY

NURSING SCHOLARSHIP PROGRAM

2017/2018

Clay Taylor Embry & Mary Almira Smith Embry Memorial Scholarship Fund

The *Clay Taylor Embry and Mary Almira Smith Embry Memorial Scholarship Fund* is a continuing, fully-funded nursing scholarship to be administered by the Tri-State Memorial Hospital Auxiliary. It is funded through an endowment trust from the above individuals and was established in May 1985.

Eligibility for the award is based on the following criteria:

- Applicant must be a high school graduate or the equivalent.
- Students must be enrolled in a full-time Health Science Program in the Fall 2017 term. **-OR-** Applicant must be a full-time nursing student entering the second year of the nursing program.
- Applicant must demonstrate a grade point average (GPA) of at least 2.5 in high school or equivalent course work. **-OR-** Must have maintained an overall GPA of 2.5 with a minimum of 2.0 in any subject during first year of nursing program or other college level classes.
- Applicants may receive this scholarship twice.
- Applicant must be available for face to face interview with Auxiliary Scholarship Committee.
- Applicant attending school in the Lewiston Clarkston Valley—Nez Perce County or Asotin County preferred.
- Auxiliary Scholarships Funds are to be used for tuition, books and labs. Funds are directly deposited to the attending college.
- Auxiliary Scholarship recipients must pledge to apply for a position at Tri-State Memorial Hospital upon graduation. If a position is available, and the applicant is hired for the position, they must commit to work at least one year after licensing. This requirement may be waived in lieu of missionary or public service commitments at the discretion of the Auxiliary Scholarship Committee.

To apply for the Embry Memorial Scholarship, please complete the attached application.

All scholarship application materials must include:

- *Application Form*
- *One Advisor/Counselor Report*
- *Two References(non-relatives)*
- *Official current grade transcript*

*Return completed application to the Community Relations Office, Tri-State Memorial Hospital, by **June 30, 2017**. After June 30, the applications will be reviewed by the Auxiliary Scholarship Committee. Award recipients will be notified no later than August 1, 2017.*

For additional information, call (509) 758-4902 or email auxiliary@tsmh.org
Mailing Address: PO Box 189 • Clarkston, WA 99403 • tristatehospital.org
Office Location: 1254 Highland Ave • Clarkston, WA

TRI-STATE MEMORIAL HOSPITAL AUXILIARY NURSING SCHOLARSHIP PROGRAM

APPLICATION FOR SCHOLARSHIP

(Please print or type all information)

Name _____
(Last) (First) (Middle)

Address _____
(Street Address and/or Post Office Box)

Graduating High School _____
(City) (State) (Zip Code)

Year of Graduation _____
(City) (State) (Zip Code)

**TO ALL APPLICANTS: PRIOR TO COMPLETING THIS APPLICATION,
PLEASE READ ALL ENCLOSED MATERIALS.**

For scholarship consideration, you must submit this completed application form, your **Official Current Grade Transcript** showing a cumulative grade point average on a 4.0 scale, **two** reference reports and an **additional report** from the principal/dean or college counselor at your graduating high school or college.

All scholarship application materials must include:

- Application Form
- One Principal/Counselor Report
- Two References (non-relative)
- Official current grade transcript

*Must be received by the Auxiliary, at Tri-State Memorial Hospital no later than **June 30.***

ALL materials MUST be mailed or delivered in a single package to:

Volunteer Coordinator
Tri-State Memorial Hospital, Inc.
PO Box 189
1254 Highland Ave
Clarkston, WA 99403
509.758.4902

JUNE 30 is the final date for receipt of applications.

DO NOT WRITE IN THIS SPACE

Number:

Auxilian:

Applicant's Name: _____

Telephone: (____) _____ Email _____

Birth date: ____/____/____ Social Security Number: Last 4-digits _____

PARENT INFORMATION (Do not complete if you are married or over age 21)

	FATHER	MOTHER
Name		
Address		
Occupation		
Employer		

FAMILY INFORMATION

Total Number of: Siblings _____ At home _____ Other dependents who live with your parents _____ Please specify _____ Your Marital Status _____ Number of children _____

SPOUSE'S INFORMATION (complete if applicable)

Spouse's Name _____ Occupation _____ Employer _____

EMPLOYMENT HISTORY (please list your most recent jobs)

Job Title	Employer	Hours Worked per Week	Length of Employment

Are you currently employed? _____ Do you plan to work next fall? _____
Do you contribute to household expenses? _____ If yes, what percentage? _____

ACHIEVEMENTS/ACTIVITIES

Achievements/Honors/Recognition (High School/College)
Extracurricular activities

Please answer the following questions as completely as possible. If more room is needed to answer any of the questions, attach extra sheets of paper, labeled with your name and the question number.

1. Why did you choose nursing as a career?

2. Briefly describe why you feel you should be a scholarship recipient?

3. What are your career plans? How does Tri-State Memorial Hospital fit into your plans?

4. What are your other goals?

List the two people you asked to complete Confidential References (*non-relatives*):

Name		
Address		
City/State/Zip		

My counselor is: Name _____
 Address _____
 City/State/Zip _____

To the best of my knowledge, the foregoing statements are accurate.

(Signature)

(Date)

Please send or deliver this form and all other application material to:

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**TRI-STATE MEMORIAL HOSPITAL AUXILIARY
NURSING SCHOLARSHIP PROGRAM**

CONFIDENTIAL REFERENCE REPORT ~ **Advisor or Counselor**

The applicant listed below is applying for a college scholarship from our Auxiliary. Your assistance in determining the worthiness of this applicant will be appreciated by our Scholarship committee-and will be kept confidential. Your cooperation is requested in *returning this form to the applicant* as soon as possible. In order for this applicant to be considered for a scholarship, **this report must be included in the application, *which must be received by the Auxiliary no later than June 30.***

Applicant to complete this information:			
NAME OF APPLICANT: _____			
(Last)	(First)	(Middle)	
Permanent Address: _____			
(Street)	(City)	(State)	(Zip)
Telephone: _ (_____) _____		Year of High School Graduation: _____	
High School Attended/Attending: _____			
(Full Name)		(City)	(State)

The following information is to be completed by the principal/counselor at the applicant's current or recently attended school and returned directly to the applicant in the sealed confidential envelope.

Applicant's current cumulative GPA: _____ (on a 4.0 scale)

What honors have been received by this applicant?

Please write below your opinion and observations concerning this applicant's strongest assets and greatest weaknesses or difficulties in being a successful college student. Also include your evaluation of the applicant's compatibility with instructors and peers.

TRI-STATE MEMORIAL HOSPITAL AUXILIARY NURSING SCHOLARSHIP PROGRAM

CONFIDENTIAL REFERENCE REPORT ~ Personal (non-relative)

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(Last)	(First)	(Middle)	
Permanent Address: _____			
(Street)	(City)	(State)	(Zip)
Telephone: () _____	Year of High School Graduation: _____		
High School Attended/Attending: _____			
(Full Name)	(City)	(State)	

The following information is to be completed by the personal reference and returned directly to the applicant in the sealed confidential envelope.

What is your association with the applicant? _____
(Teacher, Employer, Neighbor, etc.)

How long have you known the applicant? _____

In your opinion, is the applicant fully qualified as to character, personality, leadership qualities and scholastic achievement to merit consideration of an award of this kind? Yes No

Please explain:

What is your estimate of the applicant's ability and motivation in accomplishing college work?

- Superior Above average
 Average May have some difficulty and should have special guidance and attention

In your opinion, does the applicant need financial aid to attend college? Yes No

Please explain:

Any additional comments:

Signed: _____

Date: _____

Name: _____
(Please Print)

Address: _____
(Street) (City) (State) (Zip)

Telephone: _____

**PLEASE ENCLOSE THIS IN AN ENVELOPE MARKED "CONFIDENTIAL,"
SEAL IT AND RETURN IT TO THE APPLICANT.**

Return to:

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Tri-State Memorial Hospital, Inc.
PO Box 189
1254 Highland Ave
Clarkston, WA 99403
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(Last)	(First)	(Middle)		
Permanent Address: _____				
(Street)	(City)	(State)	(Zip)	
Telephone: (____) _____		Year of High School Graduation: _____		
High School Attended/Attending: _____				
(Full Name)	(City)	(State)		

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(Please Print)

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