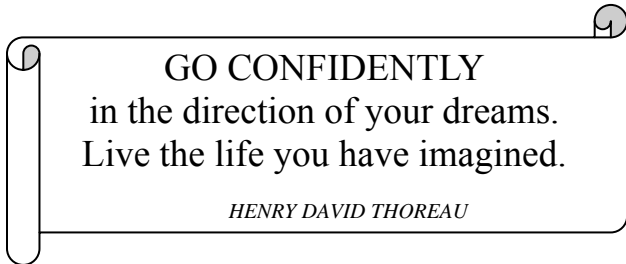


**Friends of CMC &  
Cambridge Medical Center  
Scholarship Committee**

**SCHOLARSHIP  
APPLICATION**



GO CONFIDENTLY  
in the direction of your dreams.  
Live the life you have imagined.

*HENRY DAVID THOREAU*

**If you just graduated from high school this spring please note that you are not eligible to apply for a scholarship at this time, unless you have completed your PSEO. We encourage you to apply when you have been accepted into your healthcare program.**

**If you previously received a scholarship you are not eligible to reapply in an effort to give others an opportunity.**

# INSTRUCTIONS

1. Complete the application form. Please note, only one application is needed to be considered for any of the Cambridge Medical Center scholarships. **(There is a separate application for scholarships available through the Memorial Hospital Foundation and they have their own Scholarship Committee. The medical center collects those applications as a courtesy. For questions regarding Memorial Hospital Foundation Scholarships, please contact Dr. Ray Magnuson at 763-689-1020.)**
2. Include in your application a letter stating why you wish to enter this profession, meaningful experiences which have influenced your decisions, and any special needs you may have to finance your goal.
3. Include a college transcript.
4. Sign the attached photo release form for use in possible press releases.
5. Return the completed application form no later than **April 30th** to:

Cambridge Medical Center  
**ATTN: Scholarship Committee**  
701 Dellwood St. S  
Cambridge, MN 55008  
763-688-7840

## **AVAILABLE SCHOLARSHIPS**

The Scholarship Committee awards specific scholarships as deemed appropriate.

### **GERTRUDE A. GUNDERSON NURSING SCHOLARSHIP (Friends of CMC Scholarship)**

Who may apply? Anyone who is a graduate of the area served by the medical center, and who is presently accepted into a **Registered Nurse Program** leading to a degree.

Amount and how payable? \$1000 to be paid directly to the school of the recipient's choice. Payable upon receipt of letter from the financial aid director indicating continuance in a nursing degree program.

### **CAROL BALL NURSING SCHOLARSHIP (for a non-traditional student)**

Who may apply? A single female parent over the age of 30 who is presently accepted into a **Registered Nurse Program** leading to a degree.

Amount and how payable? \$250 to be paid directly to the school of the recipient's choice. Payable upon receipt of letter from the financial aid director indicating continuance in a nursing degree program.

### **FRIENDS OF CMC SCHOLARSHIPS**

Who may apply? Anyone who is a high school graduate of the area served by Cambridge Medical Center in Cambridge, or who now resides in the area, and is **presently accepted into health career program leading to a Bachelor of Arts, Bachelor of Science, Associate degree, an accredited school granting a certification in a health care field or a post bachelor program in health care.**

Amount and how payable? There are **two \$1000** scholarships awarded. The \$1000 for each recipient will be paid directly to the school of the recipient's choice, which awards a degree or certification in the chosen field.

### **CAMBRIDGE MEDICAL CENTER SCHOLARSHIPS**

Who may apply? Anyone who is a high school graduate of the area served by Cambridge Medical Center in Cambridge, or who now resides in the area, and is **presently accepted into health career program leading to a Bachelor of Arts, Bachelor of Science, Associate degree, an accredited school granting a certification in a health care field or a post bachelor program in health care.**

Amount and how payable? There are **two \$1,000** scholarships awarded to be paid directly to the school of the recipient's choice, which awards a degree in the chosen field. This includes the 2-year RN program. Payable upon receipt of letter from the financial aid director indicating continuance in a medical field of study.

### **Cambridge Medical Center Employee/Family Scholarship**

This scholarship is awarded to an employee of the medical center or a family member in the

amount of \$1,000, who is **presently accepted into health career program leading to a Bachelor of Arts, Bachelor of Science, Associate of Arts or Science, from an accredited school granting a certification in a health care field or a post bachelor**

## SCHOLARSHIP APPLICATION

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

**Phone # (Home)** \_\_\_\_\_ **(Work)** \_\_\_\_\_ **(Cell)** \_\_\_\_\_

**Email:** \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

**CMC Employee or Family Member?** Yes or No (circle one)

**Name of CMC Family Member and Relationship:**

\_\_\_\_\_

**Age: Over 30?** Yes or No (circle one)      **Female?** Yes or No (circle one)

<b>Complete this Section if you are Married or Single with Dependent(s)</b>
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**Married:** Yes or No (circle one)

**Name of Spouse:** \_\_\_\_\_

**Your Employer:** (if applicable)

\_\_\_\_\_

**Spouse's Employer:** \_\_\_\_\_

**Number of dependent children you have (if applicable):** \_\_\_\_\_

<b>Complete this Section if you are a Dependent</b>
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**Parent's Name(s):** \_\_\_\_\_

**Phone # (Home)** \_\_\_\_\_ **(Work)** \_\_\_\_\_

**Number of siblings in family (if applicable):** \_\_\_\_\_

**Number of persons dependent upon your parents for support (if applicable):** \_\_\_\_\_

**Number of brothers or sisters presently attending college:** \_\_\_\_\_

**Sibling's Name:** \_\_\_\_\_ **School:** \_\_\_\_\_

**Sibling's Name:** \_\_\_\_\_ **School:** \_\_\_\_\_

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**High School Attended:** \_\_\_\_\_

**Year Graduated:** \_\_\_\_\_

**Have you completed your healthcare prerequisites and been accepted into your respective school?**

Yes \_\_\_ No \_\_\_

**Name of School/College:** \_\_\_\_\_

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

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**Student ID:** \_\_\_\_\_

**School of (check one)**

\_\_\_ Nursing                      \_\_\_ Physical Therapy                      \_\_\_ Medicine

\_\_\_ Medical Technology                      \_\_\_ Occupational Therapy                      \_\_\_ Dentistry

\_\_\_ Other: \_\_\_\_\_

**Household Income Range:**

If you claim you are a dependent this must be reflected in the total household income.

Less than \$20,000   

\$20,000 - \$50,000   

\$50,000 - \$80,000   

\$80,000 - \$100,000   

Greater than \$100,000   

**Estimated Total Expenses for One Year:**

Books: \_\_\_\_\_

Tuition: \_\_\_\_\_

Room/Board or  
Housing: \_\_\_\_\_

Other: \_\_\_\_\_

*Total:* \_\_\_\_\_

**Other scholarship sources this year (including dollar amount):**

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CONSENT TO USE PHOTOGRAPHS AND/OR  
**PRESS RELEASE INFORMATION**

**SUBJECT: Scholarship Applicant**

**DATE:** \_\_\_\_\_

I give permission to Cambridge Medical Center Scholarship Committee for possible use in Cambridge Medical Center publications, newsletters, or local papers. I release the CMC Scholarship Committee and all members from liability.

\_\_\_\_\_  
Signature of Scholarship Applicant

**Please ensure that your application is complete to be eligible for one of our scholarships.**

<b>Did you include?</b>	<b>Check if Completed <math>\checkmark</math></b>
1. Scholarship Application	
2. Letter to Scholarship Committee	
3. College Transcript	
4. Signed Photo Release	

*If you are awarded a scholarship a thank you is always appreciated!*