WASHINGTON HOSPITAL SERVICE LEAGUE
HEALTH CAREER SCHOLARSHIP

Health Career Scholarships are awarded annually to Washington Hospital District graduating high school seniors and/or college students pursuing studies in a health-related field.

A. **Two scholarships: Each scholarship is for $1000.00 per year and is renewable each year the student remains in a health-related program in good standing, with a 2.50 GPA or higher. The scholarship is limited to four years of undergraduate or graduate school.**

CRITERIA: Applicants who will be considered for these scholarships shall:

1. Be a U.S. citizen/permanent resident and provide proof of citizenship/permanent residency with application.

2. Be a Resident of Washington Hospital District, which includes Fremont, Newark, Union City and part of Hayward or be a current Washington Hospital volunteer.

3. Be 22 years of age or younger as of December 31st of the year in which they apply for the scholarship.

4. Have been accepted by an accredited school, college or university offering a bachelor or high degree program in a health-related field.

5. Be a full time student.

6. Submit an official high school or current college transcript with application.

7. Contribute to the community by accruing at least 100 hours of volunteer service or by working in a health-related field.

8. Submit current letters of recommendation, one each, from three of the following:
   a. Assistant Director of Volunteer Services
   b. Employer
   c. Counselor/Advisor
   d. Teacher

9. Not have been previously awarded a WHSL Health Career Scholarship.

10. **Submit by April 1st** a completed application with all of the above criteria met

Applicants who meet the above criteria will be interviewed after May 1st by a committee of people from the hospital community. Recipients of the awards will be notified in late May. **Upon verification of enrollment**, a check in the amount of $1,000.00 will be sent to the Financial Aid office of the recipient's school.

B. A one-time $1000.00 is also offered.

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1. Be a U.S. citizen/permanent resident and provide proof of citizenship/permanent residency with application

2. Be a Resident of Washington Hospital District, which includes Fremont, Newark, Union City, and part of Hayward or be a current Washington Hospital volunteer.

3. Be a 22 years of age or younger as of December 31st of the year in which they apply for the scholarship.

4. Have been accepted by an accredited school, college or university offering an associate, bachelor or higher degree program in a health-related field.

5. Be a full time student.

6. Submit an official high school or current college transcript with application.

7. Contribute to the community by accruing at least 100 hours of volunteer service or by working in a health-related field.

8. Submit current letters of recommendation, one each, from three of the following:
   a. Designee of Volunteer Services
   b. Employer
   c. Counselor/Advisor
   d. Teacher

9. Be an active volunteer at Washington Hospital.

10. Not have been previously awarded a WHSL Health Career Scholarship.

11. **Submit by April 1st** : a completed application with all of the above criteria met.

Applicants who meet the above criteria will be interviewed after May 1st by a committee of people from the hospital community. Recipients of the awards will be notified in late May. **Upon verification of enrollment**, a check in the amount of $1,000.00 will be sent to the Financial Aid office of the recipient's school.

WASHINGTON HOSPITAL SERVICE LEAGUE
HEALTH CAREER SCHOLARSHIP APPLICATION

All information submitted with this application is confidential. Please print or type. If you need additional space, please write on plain white 8 ½" x 11" paper and attach to application.

PERSONAL DATA

Name (Mr. Mrs. Ms. Miss)_____ Age_____ Birthdate_____

U.S. Citizen Yes____ No____ Last 4 digits of Social Security # XXX-XX-_____

Email address: _____

Current Address:_____

City_____ State_____ Zip_____ Phone (___)_____ Fax (___) _____

Father's Name_____ Occupation_____

Address_____ Phone (_____)_____

City_____ State_____ Zip_____ Fax (_____) _____

Mother's Name_____ Occupation_____

Address_____ Phone (_____)_____

City_____ State_____ Zip_____ Fax (_____) _____

If married, Spouse's Name_____ Occupation_____

EDUCATIONAL BACKGROUND

Name of High School_____

Address_____

City_____ State_____ Zip_____ Phone (___)_____ Fax (___) _____

Name of College_____

Address_____

City_____ State_____ Zip_____ Phone (___)_____ Fax (___) _____

SCHOOL ACTIVITIES / AWARDS

Please list awards, honors, scholarships received, and activities participated in for the last two (2) years. Prior years may be listed on a separate sheet of paper.

_____

_____

_____

Other activities and offices held (High School, College, Community Clubs)

_____

_____

_____

WORK EXPERIENCE (other than volunteer)

List all work experience in which you have participated, whether related to health care or not.

Employer	Job Title or Duties	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

PROFILE OF THE APPLICANT (Educational and Career Goals)

Scholastic standing GPA_____

Name of school planning to attend in the Fall_____

Major_____ Minor area of specialization_____

What living arrangements will you have at school?_____

_____

What health career do you plan to pursue?

_____

_____

What qualifications do you feel you have to pursue a health care career (100 words or less).

_____

_____

_____

_____

_____

Education and occupational goals as they relate to the health care industry (100 words or less)

_____

_____

_____

_____

_____

VOLUNTEER ACTIVITIES / SERVICES

Community Healthcare-Related Volunteer Services:

_____

_____

_____

_____

_____

Name of agency or institution_____
Supervisor_____ Address_____
Phone (___)_____ Fax (___) _____

Total hours_____ Hours during the last 2 years_____

Name of agency or institution_____
Supervisor_____ Address_____
Phone (___)_____ Fax (___) _____

Total hours_____ Hours during the last 2 years_____

Community-Related Volunteer Services_____

_____

_____

_____

Name of agency or institution_____
Supervisor_____ Address_____
Phone (___)_____ Fax (___) _____

Total hours_____ Hours during the last 2 years_____

Name of agency or institution_____
Supervisor_____ Address_____
Phone (___)_____ Fax (___) _____

Total hours_____ Hours during the last 2 years_____

CONSENT FOR RELEASE OF INFORMATION

"I hereby consent to the release of any information in connection with the foregoing that in the sole judgement of Washington Hospital Service league may be of assistance in evaluating my scholarship application. I hereby waive any confidentiality with respect to such information insofar as the Washington Hospital Service league is concerned, since it is my understanding that the information will be used solely for the evaluating of my application for scholarship and for no other purpose."

Signature of applicant_____

Date completed_____

RETURN COMPLETED APPLICATION BY APRIL 1ST TO:

Washington Hospital Service League
2000 Mowry Avenue
Fremont, CA 94538-1716

Attention: Scholarship Chairman

Please note: It is the applicant's sole responsibility to see that the completed application, official transcripts, and letters of recommendation are received by the Washington Hospital Service League Scholarship Committee by April 1st.

Washington Hospital Healthcare System

2000 Mowry Avenue Fremont California 94538-1716 • (510) 797-1111
www.whhs.com

PHOTO/RECORDING RELEASE FORM

I authorize Washington Township Health Care District d/b/a Washington Hospital Healthcare System (the "Hospital") to make use of my appearance for the:

PROGRAM TITLE: _____
("Program")

I understand that I am to receive no compensation for this appearance. The Hospital shall have complete ownership of the photograph(s) and recording(s). I give the Hospital the right to use my name, likeness and biographical material to publicize the Program and the services of the Hospital.

Washington Hospital Healthcare System may:

1. Photograph me and record my voice and likeness for the purpose of the production mentioned above, whether by film, videotape, magnetic tape, digitally or otherwise;

2. Make copies of the photographs and recordings so made; and

3. Use my name and likeness for the purposes of education, promotion or advertising.

I further understand the photograph(s) and recording(s) remain the property of the Hospital and that there will be no restrictions on the number of items that my name and likeness may be used, unless I notify the Hospital otherwise.

Signed
By x _____ Date: _____

Name (please print) _____

Company/Department _____ Phone/Ext. _____

Address _____ City & Zip Code _____

If under 18 years of age, a parent or guardian's signature is required below:

x _____ Date: _____