



The Valley Hospital Auxiliary (form VHA-HS2019)

Scholarship Award Application for High School Student – 2018-2019

**Please note! *All fields on this application must be fully completed if applicable to you, in order to submit your application and be considered eligible. All information will be maintained in the strictest confidentiality.*

Today's Date: _____

Personal Information:

Last Name _____ First Name _____

Street _____ City _____ State _____

Zip _____ Date of Birth _____ Email _____

Cell Phone _____ Home Phone _____

Father or Male Guardian: Last Name _____ First Name _____

Mother or Female Guardian: Last Name _____ First Name _____

Volunteering Information:

If you volunteer at the Valley Hospital during the current school year or the summer:

Name of Department _____ Contact _____

Hours Worked Per Week _____

Name of Department _____ Contact _____

Hours Worked Per Week _____

Name of Department _____ Contact _____

Hours Worked Per Week _____

Volunteer Activities Other than Valley:

Hobbies, Sports, Clubs:

Work History:

1. Dates Worked _____ Hours Per Week _____

Job Description _____ Contact Name _____ Phone _____

2. Dates Worked _____ Hours Per Week _____

Job Description _____ Contact Name _____ Phone _____

3. Dates Worked _____ Hours Per Week _____

Job Description _____ Contact Name _____ Phone _____

ACT Score: _____ Date Taken _____

SAT Scores: Verbal _____ Math _____ Date Taken _____

GPA (beginning of 8th semester): _____

Educational Plans for Health-related Career: (Indicate career and courses planned in future) _____

Essay Question: (On a separate sheet of paper, in 250 typed words or more) explain why you are including a health-related field in your educational plans and be as specific as possible, for example, discuss what or who inspired you. Include what The Valley Hospital means to you and why you are applying for a scholarship from the Valley Hospital Auxiliary.

Applicant's School:

Full Name of School _____

Street _____ City _____ State _____ Zip _____

Current Grade _____

Name of Guidance Counselor _____ Phone _____

List other scholarships, grants and loans you are applying for:

What College/University do you plan to attend in the fall of 2018? _____

Applicant's Signature

Parent/Guardian Signature

Counselor or Dean's Signature

NOTE! *No exceptions will be made to the following two firm deadlines*:

To consider this application valid, the following criteria **must be submitted by APRIL 25, 2019 with the exception of # 4:**

1. ___ Application is preferred typed submission using fillable form. Handwritten submissions must be legible and neat in black ink.
2. ___ Application is completed and with original signatures (no copies) where necessary.
3. ___ High school transcript is attached.
4. ___ Evidence of acceptance by your choice of school (if not available from college by April 25th, evidence is required from college before scholarship check will be mailed).
5. ___ Two letters of recommendation are included. Please submit at least one letter from a supervisor where you volunteer or work.
6. ___ Include your completed 250 word essay.

Return all Information by mail to:

The Valley Hospital Auxiliary, 223 North Van Dien Avenue, Ridgewood, New Jersey 07450

Attn: Bobbi Zientek, Auxiliary Coordinator