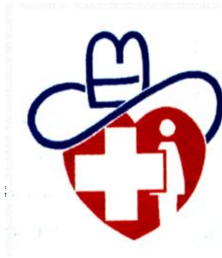
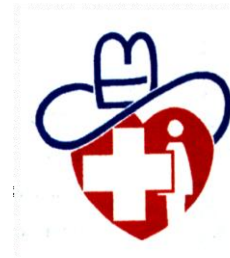


DAHL MEMORIAL HEALTHCARE ASSN. INC.
PO BOX 46
EKALAKA, MT 59324
406-775-8739



HEALTH PROFESSIONS SCHOLARSHIP APPLICATION FORM

NAME: ____

First Middle Last

ADDRESS: ____

____

____

PHONE: ____

COLLEGE, UNIVERSITY, AND/OR HEALTH PROFESSIONS PROGRAM YOU ARE ATTENDING OR ACCEPTED FOR ENROLLMENT

- **Name and Address of College or University**

  ____

  ____

  ____

- **Name of Health Professions Education Program:**
  (Nursing, Physician Assistant, Nurse Practitioner, Physical Therapy, Occupational Therapy, Respiratory Therapy, Medical Technology, Laboratory Technology, Pharmacy, Other)

  ____

- **Degree and/or Certification and Expected Date of Completion:**

  ____________________ ____________________

  Degree Date

- **Date of Enrollment or Expected Enrollment:**

  ____

HIGH SCHOOL ATTENDED:

- Name and Address: ______________________________
  ____
  ____
- Date of Graduation: ______________________________
- Grade Point Average: ______________________________
- Academic Honors and/or Awards:
  ____
  ____
  ____
  ____
- Other Recognitions and/or Achievements:
  ____
  ____
  ____
- SAT or ACT Scores: ______________________________
  (specify SAT or ACT)

COLLEGES OR UNIVERSITIES ATTENDED:

- Name and Address: ______________________________
  ____
  ____
- Curriculum/Major: ______________________________
- Degree: ______________________________
- Currently Enrolled: ______________________________
  (yes or no)
- Date of Graduation: ______________________________
- Grade Point Average: ______________________________
- Academic Honors and Awards:
  ____
  ____
  ____

- Other Recognitions or Achievements:

DEMONSTRATED INTEREST IN THE HEALTH PROFESSIONS:

(List and/or discuss any employment, volunteer work, school projects, etc. that would give an indication of your interest in and/or understanding of health care delivery systems, health professions education and medical/biomedical research.)

ESSAY/STATEMENT OF PROFESSIONAL GOALS:

(This essay or statement should be no longer than one page. It should describe your reasons for choosing one of the health professions as a career and your interest in and commitment to health care delivery systems. Attach the completed essay to this application form.)

REFERENCES:

List three persons as references who can verify your academic and personal qualifications to qualify for this scholarship award. Please ask your references to submit a letter to the Chairman of the Scholarship Committee:

Scholarship Committee
Dahl Memorial Healthcare Assn. Inc.
P.O. Box 46
Ekalaka, MT 59324

- Reference: ______________________________
  ____
  ____
- Reference: ______________________________
  ____
  ____
- Reference: ______________________________
  ____
  ____

REQUIRED DOCUMENTS TO ACCOMPANY THIS APPLICATION:

- High School Transcript
- Verification of SAT or ACT Scores
- College/University Transcript (if Applicable)
- Verification of Acceptance/Admission to Health Professions Training Program or to a College or University
- Essay/Statement of Professional Goals

DEADLINE OF APPLICATIONS:

The completed application with all attachments must be received no later than **May 1st.**
The application should be sent to: Chairman of the Scholarship Committee
Dahl Memorial Healthcare Assn. Inc.
P.O. Box 46
Ekalaka, MT 59324-0046

I agree that if I am awarded a scholarship by the Dahl Memorial Healthcare Assn. Inc. that I will use the money for the intended purpose.

______________________________ ______________________________
Signature of Applicant Date