



**MEDICAL STAFF SCHOLARSHIP APPLICATION**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

FULL ADDRESS: \_\_\_\_\_

PARENTS/GUARDIAN: \_\_\_\_\_

SCHOOL NAME/ADDRESS: \_\_\_\_\_

GRADUATION YEAR: HIGH SCHOOL: \_\_\_\_\_ COLLEGE (if prior degree): \_\_\_\_\_

\*RANK IN CLASS: \_\_\_\_\_ \*IN CLASS OF: \_\_\_\_\_ \*GPA: \_\_\_\_\_ (\*high school seniors only)

PROPOSED COURSE OF STUDY: \_\_\_\_\_

LEADING TO (DEGREE): \_\_\_\_\_

ACCEPTED/ENROLLED AT (COLLEGE): \_\_\_\_\_

EXPECTED START/GRADUATION DATE: \_\_\_\_\_

Do you intend to utilize your education in healthcare at this hospital, or in this county?  Yes  No

Brief statement as to reasons for entering proposed course of study:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please attach a recommendation letter (cannot be from a relative or friend) and a Personal Information Sheet (i.e. resume).

All information submitted by me on the application and attached Personal Information Sheet is correct and accurate. I understand that if any false information is submitted, I will be required to repay any monies given to me by the Medical Staff.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

Return to: Iroquois Memorial Hospital Attn: Michelle Fox, 200 Fairman Watseka, IL 60970  
Applications must be received by April 30, 2026