



SSMHealth.

Good Samaritan Hospital Foundation

Dr. Jean M. Modert Scholarship

Student Application

APPLICATIONS MUST BE RECEIVED BY 4:30 P.M. CDT, APRIL 1st

APPLICANT INFORMATION				
Last Name:		First Name:		Middle Initial:
Maiden Name/Other Names Used:			SSN#:	
Address:			Telephone (home):	
City:	State:	Zip:	County:	
E-mail:			Telephone (cell):	
How long have you lived at your address?				
Are you a dependent of a SSM Health Illinois Employee? Yes No				
Are you eligible to work in Illinois two years following graduation? Yes No				
How did you learn about this scholarship?				
PROGRAM TYPE				
Indicate the program in which you are enrolled in or to which you have been accepted				
Audiologist	Nursing (LPN)	Respiratory Therapist (RRT)		
Clinical Social Worker	Occupational Therapist (OT or OTR)	Speech/Language Therapist		
Medical Records	Pharmacist (Pharm B or Pharm D)	Other Licensed/Registered		
Nurse Anesthetist	Physical Therapist (PT)			
Nursing (RN)	Registered Radiologic Technologist (RT)			
Please submit an original transcript for each prior academic institution attended with this application. If you have a GED, include the original transcript with signature.				
Circle the highest grade completed: High School: 9 10 11 12 GED College: 1 2 3 4				

All information is confidential and for programmatic purposes only.

High School attended and location:			Graduation Date:
Technical/Vocational School Attended and Location:		Dates Attended:	Degree Earned:
College/University Attended and Location:	Dates Attended/Hours:	Graduation Date:	Degree Earned:
College/University Attended and Location:	Dates Attended/Hours:	Graduation Date:	Degree Earned:
IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH SEPARATE SHEET.			

ENROLLMENT VERIFICATION			
Name of School/College/Institution:		Address:	
Contact Person:	Title of Contact Person:	Telephone:	
Current Year in the Program:	Academic Year:	Program Start Date:	Cost per semester?
APPLICANT MUST SHOW EVIDENCE OF ACCEPTANCE TO AN ACADEMIC PROGRAM AND SHOW PROOF OF ENROLLMENT.			
EMPLOYMENT			
Are you currently employed? Yes No	Start Date:	Do you plan to remain with this employer? Yes No	
If yes, name of employer:		May we contact you at work? Yes No	
Address of Employer:		Work Phone:	
PERSONAL STATEMENT			
<p>On a separate sheet, submit a personal statement describing your commitment to SSM Health Good Samaritan Hospital – Mt. Vernon, IL. Include information detailing the need and benefits of the training/education. This statement is not to exceed one single-spaced typewritten page.</p>			

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List your extracurricular, community, volunteer, or health care activities.

(It is important for the selection committee to have this information from all applicants.)

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INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED. QUESTIONS REGARDING THE APPLICATION AND SELECTION PROCESS SHOULD BE DIRECTED TO THE SSM HEALTH GOOD SAMARITAN HOSPITAL FOUNDATION AT 618-899-1048 or email Rebecca.pierce@ssmhealth.com

I certify that the information contained in this application is true, complete, and correct to the best of my knowledge, and that all funds will be used for educational-related expenses in the current academic year. I hereby authorize the release of personal, scholastic, and financial information related to my educational status from any academic institution I have attended in the past, am currently enrolled or may be enrolled as a student in the future, to the SSM Health Good Samaritan Foundation.

Signature of Applicant:

Date:

NOTE: *This student scholarship program is a competitive process, and only eligible applications will be evaluated. All eligible applications may not receive funding. **The scholarship application must be completed in its entirety to be eligible for consideration.***