

APPLICATION FOR PHYSICIAN MEMORIAL SCHOLARSHIP

WILSON MEMORIAL HOSPITAL
915 W. Michigan St.
Sidney, Ohio 45365

Date: ___ / ___ / ___

Name _____	Social Security _____
Address _____	
Home Phone () _____	Daytime Phone () _____

EDUCATION

High School Attended _____	Phone Number () _____
Address _____	
Grade Point Average _____	
College Status: <input type="checkbox"/> Enrolled and Proof of Enrollment	<input type="checkbox"/> Accepted to college - start date _____
<input type="checkbox"/> Currently attending - number of years completed _____	(mm/dd/yyyy)
Grade point average _____ (Attach Transcript)	
School of Medicine/Osteopathic Status: <input type="checkbox"/> Accepted	<input type="checkbox"/> Currently attending - number of years completed _____
Grade point average _____ (Attach Transcript)	
College _____	Phone Number () _____
Address _____	

WORK EXPERIENCE

Present Employer _____	Job Title _____
Address _____	
Phone Number () _____	
Starting (Mo./Yr.) _____	Ending (Mo./Yr.) _____
Supervisor's Name _____	
Past Employer _____	Job Title _____
Address _____	
Phone Number () _____	
Starting (Mo./Yr.) _____	Ending (Mo./Yr.) _____
Supervisor's Name _____	

EXTRACURRICULAR OR CIVIC ACTIVITIES

Please list activities in which you are/were involved and include dates of involvement:

REFERENCES

Please list three (3) academic, work or personal references

Name _____ Title _____

Address _____ Phone Number () _____

Name _____ Title _____

Address _____ Phone Number () _____

Name _____ Title _____

Address _____ Phone Number () _____

PERSONAL STATEMENT

Please include personal history, achievements, accomplishments, awards, goals and ambitions.

(CONT.)

I hereby certify that the above information is true and correct. The companies, schools, and persons named herein may give information regarding me and I hereby release them from all liability for doing so.

Date

Applicant Signature

If you are under 18 years of age, a parent's or guardian's signature must be obtained to release the requested information.

Date

Parent's or Guardian's Signature

APPLICATIONS SHOULD BE RETURNED TO THE HUMAN RESOURCES OFFICE OF WILSON MEMORIAL HOSPITAL VIA U.S. MAIL OR EMAIL TO: dhearne@wilsonhospital.com

MAILING ADDRESS:

*WILSON MEMORIAL HOSPITAL
HUMAN RESOURCES/PHYSICIAN MEMORIAL SCHOLARSHIP
915 W. MICHIGAN STREET
SIDNEY, OH 45365*