Winona Health Foundation

Winona Health Foundation Healthcare Scholarship Program APPLICATION

Please complete this application, attach narrative, and submit to the Winona Health Foundation by **May 1.** Applications received after this deadline or incomplete will be ineligible. Awardees will be notified by June 1. **Please type or print in black ink.**

Date: _____ Applying for: ___ Advanced Clinical Scholarship ___ Associate Scholarship

Applicant's name: _____

Position at Winona Health: _____ Department: _____

Your current employee status: ___ FT ___ PT ____ Number of hours worked per pay period
Length of employment with Winona Health: _____

Daytime phone number: _____Email address: _____

Mailing address: _____

Name of college/technical school you are or will be attending: _____
Date of enrollment: _____
Current enrollment status: _____

Degree/Program pursuing: _____

Most recent cumulative grade point average (GPA): _____

Employment history at Winona Health: _____

_____

Summary of volunteer/community service experiences: _____

_____

_____

On a separate sheet of paper, please share 1) your career and professional goals and 2) why you should be selected to receive a scholarship. **Please type and double-space your response. Limit 1 page.**

Applicant signature**:** _____