



## **Nursing Scholarship**

**Memorial Hospital and Health Care Center's Mission is to provide Christ's healing mission of compassion to empower us to be for others through quality and excellence. In its pursuit of achieving Magnet designation for excellence in nursing services, providing high quality care, and in keeping with its mission, MHHCC supports the growth and development of current and future nurses.**

### **What is the Memorial Hospital Foundation Nursing Scholarship?**

- The vision of the scholarship program is to identify a selected number of future nursing professionals to promote the profession of nursing and cultivate future nursing leaders within our community.
- The nursing scholarship is funded by the Memorial Hospital Foundation and payable to the individual recipient. The scholarship allows recipients to utilize the funds at their discretion to support their successful completion of their degree from an accredited school of nursing.
- This is a unique opportunity for nursing students that begins in their final year of nursing education in the fall semester. The scholarship is intended to support future nursing professionals as they achieve their educational objectives, nursing licensure, and career goals in nursing at MHHCC.

### **What are the requirements of the scholarship program?**

- Interested applicants must be entering their final year of nursing education in the fall, and must be in good standing with an accredited school of nursing.
- The scholarship candidate will, at the time of application, have a GPA of 3.2 or higher.
- The scholarship candidate will graduate either December or May and be eligible to take the NCLEX exam.
- Students will apply for a nursing position with MHHCC their last semester of school.
- As part of the program, the future nursing professional must sign an agreement to remain employed at MHHCC as a Registered Nurse in a direct patient care area full time for a period of two (2) years.
- If separation of employment occurs before the 2-year obligation is met, the entire scholarship amount must be repaid to Memorial Hospital Foundation. A Student Commitment Agreement is required to be signed by the recipient.

### **What are the scholarship benefits?**

- An amount of \$5,000.00, granted to each scholarship recipient to assist with successful completion of his/her nursing curriculum.
- Full time Nursing position at MHHCC focusing on critical shortage areas.
- Individualized nursing orientation and unit orientation with preceptor.
- Post-employment opportunities for specialty certification and ongoing continuing education.
- Opportunity to participate in the MHHCC Nurse Onboarding.

# MEMORIAL HOSPITAL FOUNDATION

## NURSING SCHOLARSHIP

**TYPE OR PRINT ALL INFORMATION**

APPLICATION POSTMARK DEADLINE IS: **March 15th**

Completeness and neatness ensure your application will be reviewed properly.

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**APPLICANT  
DATA**

_____	_____	_____
Last Name	First Name	Middle Initial
_____		
Permanent home mailing address		
_____	_____	_____
City	State	Zip Code
_____	_____	
Phone	E-mail Address	
_____	_____	
Nursing Program/School	Anticipated graduation month and year	

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If space provided in any section is inadequate, you may continue on additional sheets of paper using the same format. DO NOT repeat information already reported on the application form. Your name, address and name of this scholarship program should be included on all attachments.

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The student is responsible for submitting all materials to MHHCC Human Resources by identified timeframes. Incomplete applications will not be evaluated. This application becomes complete and valid only when MHHCC Resources has received all of the following materials:

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**APPLICATION  
CHECKLIST**

Student Application (this packet must be submitted on line or emailed).  
Emailed to: Brooke Ingram at [bingram@mhcc.org](mailto:bingram@mhcc.org)

Mailed to:

**Human Resources - Memorial Hospital Foundation Nursing Scholarship**  
**800 w 9<sup>th</sup> St**  
**Jasper, IN 47546**  
**Attention: Brooke Ingram**

Current official transcript  
(can be mailed or electronically requested).

Student Clinical Performance Evaluation Form  
(Last page of application, form must be signed by student and sent to instructor).

**WORK EXPERIENCE**

List your work experience during the past four years. Indicate dates of employment for each job and approximate number of hours worked each week.

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Present or Last Employer \_\_\_\_\_ Phone (including area code) \_\_\_\_\_

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Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Name While Employed \_\_\_\_\_ Job Title \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_

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Supervisor's Name \_\_\_\_\_

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Summary of Duties \_\_\_\_\_

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Reason for Leaving \_\_\_\_\_

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Present or Last Employer \_\_\_\_\_ Phone (including area code) \_\_\_\_\_

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Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Name While Employed \_\_\_\_\_ Job Title \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_

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Supervisor's Name \_\_\_\_\_

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Summary of Duties \_\_\_\_\_

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Reason for Leaving \_\_\_\_\_

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**ACTIVITIES, AWARDS AND HONORS**

List all school activities in which you have participated during the past four years (e.g. student government, music, etc.) List all community activities in which you have participated without pay during the past four years (e.g. Boy/Girl Scouts, hospital volunteer). Note all special awards, honors, and offices held. Indicate whether high school or college activities.

Activity	Number of Years Participation	Special Awards, Honors	Offices Held



**PLEASE READ AND SIGN**

I voluntarily authorize Memorial Hospital and Health Care Center to make a thorough pre-employment investigation, including a limited criminal history background check for the purpose of qualifying for a Memorial Hospital Foundation Nursing Scholarship. I understand that I have the right to obtain a copy of that report at my own expense and to challenge any information that I believe to be inaccurate. I hereby authorize former and present employers and others to provide or verify any information they have regarding my employment or me and release them from any liability for furnishing such information to Memorial Hospital and Health Care Center. I understand that scholarship qualification and employment is contingent on satisfactory outcomes of reference and background checks. The information in this document that I have provided is true and complete, and I have met the eligibility requirements of the program as described. False statements on this scholarship application and employment-related documents shall be considered sufficient cause for denial of scholarship qualification. Falsification of information may result in termination of any scholarship granted upon discovery of such falsification. If I receive a Memorial Hospital Foundation Nursing Scholarship and an offer for employment, I agree to have a medical evaluation and understand that any subsequent employment is contingent upon passing that evaluation. As an employee, I agree to take such future medical evaluation as may be lawfully required by MHHCC. If I am employed, I understand that I may be required to work weekends, holidays and overtime and hereby agree to do so. I agree to accept a temporary shift or unit change whenever emergency conditions warrant. If employed, I agree to abide by the policies, procedures and rules of MHHCC and the department to which I am assigned. I further agree to protect the confidentiality and privacy of any information regarding MHHCC and its patients. I acknowledge that decisions of MHHCC Hospital and its Selection Committee are final. This application and its attachments become the property of MHHCC. (It is recommended that you keep a copy for your files.)

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Applicant's Signature for Memorial Hospital Foundation Nursing Scholarship Program and Employment Application Records	Date
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**STUDENT AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby request and authorize you and your institution to provide the information requested and release you and your institution from any liability resulting therefrom. All information provided to Memorial Hospital and Health Care Center will be held in confidence and used for the specific purpose of the Nurse Intern Application process.

Student Name (please print) \_\_\_\_\_

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

**STUDENT PERFORMANCE EVALUATION**

(to be completed by nursing faculty)

School of Nursing \_\_\_\_\_ Instructor \_\_\_\_\_

Please use a scale of 1 to 5 (1 = Unsatisfactory, 5 = Excellent) to rate the student on the following performance criteria:

- |                                          |                                                   |
|------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Attendance      | <input type="checkbox"/> Organizational Skills    |
| <input type="checkbox"/> Initiative      | <input type="checkbox"/> Integrity                |
| <input type="checkbox"/> Quality of Work | <input type="checkbox"/> Cooperation              |
| <input type="checkbox"/> Attitude        | <input type="checkbox"/> Relationship with Others |
| <input type="checkbox"/> Team Work       | <input type="checkbox"/> Communication Skills     |

Comments/Strengths/Areas for Improvement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I would recommend this student for the Memorial Hospital Foundation Nursing Scholarship:

Yes  No

If no, why not: \_\_\_\_\_

\_\_\_\_\_

Faculty Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_

**\*Submit this release of information and evaluation form to:**

Human Resources, Attn. Brooke Ingram  
Memorial Hospital and Health Care Center  
800 W Ninth Street  
Jasper, IN 47546

OR via email to: [bingram@mhcc.org](mailto:bingram@mhcc.org)

If you have any questions, please contact Human Resources at 812-996-6326.