

DR. MARVIN “PETE” ROSS SCHOLARSHIP

In Cooperation with Carroll County Memorial Hospital Foundation

Scholarship Application Packet

The **Dr. Marvin “Pete” Ross Scholarship**, honoring Dr. Ross’ 45 years of service to Carroll County, will offer a \$1,500 scholarship for students continuing education in a health-related field. Students must fully complete the enclosed application in order to be considered.

Eligibility:

The scholarship will be granted to a student who has successfully completed one year of related education and resides in Carroll, Chariton or Lafayette Counties, Missouri. The student must be attending an accredited college, university, or specialized healthcare professional school.

The following minimum criteria must be met:

- U.S. citizen or permanent resident and have completed a minimum of one year of post-secondary education in a health-related field.
- Student must be enrolled full-time in college or specialized healthcare professional school. Proof of enrollment at post-secondary institution shall be required to release award funds.
- Preference will be given to candidates who demonstrate strong educational motivation, interest in pursuing a healthcare related career, demonstrate group leadership skills through their activities in school, church, youth groups, community volunteer efforts and/or work experience and have an interest in returning to Carroll County after college.
- Work experience, and letters of recommendation are additional criteria in the selection process.

Scholarship Rules:

- Scholarship check will be made payable to the recipient AND to the educational institution.
- Recipients are encouraged, but are not required to attend a regular scheduled meeting of the **Carroll County Memorial Hospital Foundation Board of Directors to receive the scholarship.**

Application Instructions:

Application Form

Please read all questions carefully, and answer them as completely as you can. Please PRINT or TYPE your answers clearly. Your completed application will represent you to the Scholarship Committee. Mail or deliver your completed application packet directly to Carroll County Memorial Hospital Foundation.

Letters of Recommendation

Choose two (2) people to write letters of recommendation for you. It is strongly recommended that one letter come from a professor or instructor and one letter come from an employer or friend (non-family related) who knows you through work or volunteer activities. Please enclose the letters with this application.

Transcripts of Grades

Your application must include a copy of your most recent transcripts.

Student Personal Statement

Write a statement explaining the reasons you are applying for this scholarship, your plans for the future, and your short and long-term goals. You should also include any other information about yourself, your background, your educational achievement, etc. which will help the Scholarship Committee to evaluate your potential.

Dr. Marvin "Pete" Ross Scholarship Application Form

Instructions: <ul style="list-style-type: none">• Please read all questions carefully.• Answer questions completely.• PRINT or TYPE your answers clearly. Remember that your completed application will represent you to the Scholarship Committee	<ul style="list-style-type: none">• Please mail your completed application to Carroll County Memorial Hospital Foundation, Attn: Kris Kemble, 1502 N Jefferson, Carrollton, MO 64633.• Applications must be turned in by April 11, 2023. No late applications will be accepted.• Selections will be made by April 30, 2023. You will be notified by mail if you are selected.
Personal Information	Educational Information
Name	Name of college or specialized healthcare professional school
Street Address	Are you requesting funds to continue at this institution? Yes <input type="checkbox"/> No <input type="checkbox"/>
City, State Zip	If not, what is the name of the college or school you plan to attend?
Phone Number (Home) E-mail Address	If applying for another school, have you been accepted? Yes <input type="checkbox"/> No <input type="checkbox"/>
	What is your major?
	What is your intended career?
Are you a U.S. citizen? Yes <input type="checkbox"/> No <input type="checkbox"/> If not, are you a permanent resident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Current G.P.A. _____

Financial Information

List estimated educational expenses for an academic year at preferred school (also referred to as Cost of Attendance):

Tuition & Fees: _____
Books: _____
Personal Expenses: _____
Room & Board: _____
Transportation: _____
Other (describe): _____
Total Expenses: _____

List anticipated or known sources of support to meet expenses listed:

Part-time work: _____
Loans: _____
Grants & Scholarships: _____
Parent's Contribution: _____
Your Savings: _____
Total Resources: _____
Total Deficit: _____
(Expenses minus Resources)

Please Complete All Blanks

Activities, Interests, Awards, etc. (use additional sheets if necessary)

1. List organizations, clubs, extra curricular, and community activities in which you have been active:

2. Describe why you are pursuing a career in Healthcare:

3. Please list school activities, honors, or awards you have received:

4. Will you be applying for other scholarships, grants or aid? Yes No
- a. If yes, please specify:
- | Name of Scholarship(s) | \$ AMT of Scholarship | Has Scholarship been awarded |
|------------------------|-----------------------|------------------------------|
|------------------------|-----------------------|------------------------------|

Work Experience:

Are you currently employed? Yes No

If so, list employer(s), type of job, and hours per week you work:

What types of past employment have you had?

In submitting this application for review, I agree:

- That the information contained in it is true, to the best of my knowledge.
- If I am granted an award, barring any unforeseen circumstances, I will continue my plans for study as indicated in this application.
- I have enclosed these required portions of the application:

- Completed Application Form
- Transcripts
- Student's personal statement
- Letters of recommendation

Name (Printed)

Signature

Date

Questions? Call Kris Kemble at 660-329-6001 or email at krisk@ccmhospital.org

Applications are to be sent to: Carroll County Memorial Hospital Foundation
Attention: Kris Kemble
1502 N. Jefferson St., Carrollton, MO 64633