

**LOGAN MEDICAL CENTER FOUNDATION
HS Senior SCHOLARSHIP APPLICATION**

LMC Foundation
P.O. Box 1017
Guthrie, Ok. 73044
405-260-4377

Name: _____

Address: _____
Street City State Zip

Telephone No: _____ Date of Birth: _____

Title of Education Program: _____

College or School selected: _____

Date to attend: _____ Location: _____

In the space provided below, please explain why you have chosen to pursue this field in healthcare.

Signature Date: _____

LOGAN MEDICAL CENTER FOUNDATION SCHOLARSHIP High School Senior Application

PURPOSE

The Logan Medical Center Foundation Scholarship has been established for the purpose of promoting educational opportunities for HS seniors of Logan County in the areas of healthcare.

CONDITIONS

1. Recipient must use the scholarship in an educational institution maintaining an approved health careers course of study. Evidence of this will be required.
2. Recipient during the course of study must maintain a 2.7 grade point average or better on a 4.0 scale. Official transcript will be required.
3. Recipient must pursue course of study indicated in application.
4. Applicant must be a citizen of Logan County at the time of application.
5. Applicant must present two letters of recommendation. It is recommended that one be from an educator and one a personal reference from a community leader.
6. Applicant must attach an official High School transcript with ACT scores.

SELECTION PROCEDURES

1. Complete applications must be received by the LMC Foundation by _____ April 9, 2011 _____.
2. Applications will be reviewed by a Committee appointed by the Foundation.
3. The Foundation will have final approval authority for awarding scholarships.
4. Scholarships will be awarded based upon the following factors:
 - a. Scholastic record
 - b. Evidence of community service
 - c. Evidence of leadership
 - d. Financial need
5. All applicants will be notified as to whether they received a scholarship or not. Awards are made without regard to race, color, creed, religion, sex, disability, and national origin.

I am applying for financial assistance as an incentive to further my education in the healthcare field. The Logan Medical Center Foundation is given permission to contact any parties or to obtain the sources of information, which it deems necessary to verify my eligibility for this scholarship.

Applicant Signature: _____ Date: _____

Foundation Board
Approval: _____ Date: _____