



For committee only
<input type="checkbox"/> High school
<input type="checkbox"/> Family Member
<input type="checkbox"/> Employee
<input type="checkbox"/> College

**SIOUX CENTER HEALTH SCHOLARSHIP APPLICATION**

**Please Print Neatly or Type All Information**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

If you are a high school student, Parents' Name(s): \_\_\_\_\_

School currently attending: \_\_\_\_\_  Not in school

Current Year/Grade: \_\_\_\_\_ Current grade point average? \_\_\_\_\_

Year/Grade in Fall 2024: \_\_\_\_\_

Are you or a family member currently employed at Sioux Center Health?  No  I am  a Family Member

In what position? \_\_\_\_\_ If family, what relationship to you? \_\_\_\_\_

Current Primary Care Provider/Family Physician: \_\_\_\_\_

College, University or Vocational School you plan to attend in Fall 2024:

Name: \_\_\_\_\_

City, State: \_\_\_\_\_

Are you currently enrolled or have been accepted for enrollment?  Yes  No

Health care career planning to pursue: \_\_\_\_\_

How will your education benefit or impact Sioux Center Health? \_\_\_\_\_

List school, extracurricular and volunteer activities you are involved in: \_\_\_\_\_

Have you received a scholarship from Sioux Center Health before?  Yes  No

Have you applied for a Sioux Center Health Scholarship before?  Yes  No

- ✓ **On a separate piece of paper, briefly describe why you have chosen a health care related field.**
- ✓ **Please submit a letter of reference from one of your teachers or a supervisor (work or volunteer).**
- ✓ **Please include a copy of your unofficial transcripts, if currently attending college**
- ✓ **Application Deadline: March 6, 2024**
- ✓ **Return Applications to:** Sioux Center Health

Foundation Scholarship  
1101 9<sup>th</sup> St SE  
Sioux Center, IA 51250  
or via email: Dorinda.oostenink@siouxcenterhealth.org