

**CASA GRANDE COMMUNITY HOSPITAL FOUNDATION**  
**\$1,000 SCHOLARSHIP 2019-2020 APPLICATION to be used for the 2020-2021 School Year**

You are eligible to apply if you can answer “yes” to the following three questions:

1. Do you plan to enroll full time in an accredited vocational school, college, or university for a career in the human health care field?
2. Are you a legal resident of the geographic areas served by Banner Casa Grande Medical Center/Casa Grande Community Hospital Foundation (western Pinal County)?
3. Can you submit proof of registration and acceptance to your chosen school to Kaitee-Doll-Bell with Banner Casa Grande Medical Center Volunteer Services/Foundation by **August 31, 2019** for the Fall semester and by **January 31, 2020** for Spring Semester? (A check will then be sent to you for use towards tuition, books, fees, and/or room and board at the school of choice. The vocational school, college, or university attended must be accredited or recognized as an approved program by the appropriate agencies.)

**THE APPLICANT MUST SUBMIT THEIR COMPLETED APPLICATION PACKET TO THE VOLUNTEER SERVICES DEPARTMENT AT BANNER CASA GRANDE MEDICAL CENTER POSTMARKED BY MAIL OR HAND DELIVERED BY THE DEADLINE OF 4:00 PM, WEDNESDAY, APRIL 1, 2020.**

**PLEASE USE THIS CHECKLIST TO ENSURE THAT YOUR APPLICATION IS COMPLETE.**

- Personal Data Form filled out completely (2 pages; attached).
- Educational Data Form filled out completely (attached).
- Signed Privacy Act Consent Form (release form is attached). Completely fill in this form.
- An official transcript or copy of GED provided by last school attended. GPA on Educational Data Form only is not sufficient.
- A letter to the committee from the applicant explaining their need for this scholarship. The applicant should state why they want to attend school of choice and why they wish to pursue an education in this field. Any enlightening comments are welcome. This statement is very important in the consideration of the scholarship recipients chosen by the committee.
- Three (3) letters of recommendation; one of the letters **must** be from someone outside the academic field.
- Financial sheet (this should be a copy of pages 1 and 2 of the Federal Tax Return Form of parent or legal guardian [and/or self, if applicable] for fiscal year). This information will be kept in strict confidence. This includes child support aid.

**FACTS PERTAINING TO THE SCHOLARSHIP:**

1. All of the above requirements must be met and included in your application to be considered by the committee. **Please check that everything is completely filled in and included before mailing – if any requirement is not met, you will be disqualified.** Any decisions by the Scholarship Committee are final.
2. Scholarships are given for an academic year (2 semesters) based on a student’s scholastic achievement, financial need, motivation, and character. Recipients must take a full load of classes each semester. A full load is determined by the vocational school, college, or university the recipient is attending. If a recipient does not take a full load of classes while the award is in effect, funds for that semester must be returned to the Scholarship Fund prior to the end of that semester.
3. If a recipient drops out of school while the award is in effect, funds must be returned to the Scholarship Fund commensurate with the school year remaining.
4. Return Application Packet no later than **4:00 p.m., Wednesday April 1, 2020** to:  
Banner Casa Grande Medical Center  
Attn: Kaitee-Doll-Bell Volunteer Services Executive Director of Foundation & Volunteer Services  
1800 E. Florence Boulevard  
Bldg A, Suite 115  
Casa Grande, AZ 85122  
Phone (520) 381-6541

**CASA GRANDE COMMUNITY HOSPITAL FOUNDATION  
SCHOLARSHIP APPLICATION  
PERSONAL DATA FORM**

NAME: \_\_\_\_\_ DATE OF APPLICATION: \_\_\_\_\_

PERMANENT HOME ADDRESS (NO POST OFFICE BOX NUMBER, PLEASE):

EMAIL ADDRESS (\*\* Required\*\*) \_\_\_\_\_

STREET: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

List jobs held from present and past (attach separate sheet, if necessary):

Name of Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

Duties: \_\_\_\_\_

Dates of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

Duties: \_\_\_\_\_

Dates of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

Duties: \_\_\_\_\_

Dates of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

Duties: \_\_\_\_\_

Dates of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

Duties: \_\_\_\_\_

Dates of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_



**CASA GRANDE COMMUNITY HOSPITAL FOUNDATION  
SCHOLARSHIP APPLICATION  
EDUCATIONAL DATA FORM**

Name and Location of High School and/or Colleges attended:

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Location)

Date of Graduation/GED (month and year): \_\_\_\_\_

Cumulative High School GRADE POINT AVERAGE (verified by High School Official): \_\_\_\_\_ (A=4.0)

Verified by: \_\_\_\_\_

(Signature)

\_\_\_\_\_  
(Title of School Official)

College, Vocational School, or University you plan to attend:

\_\_\_\_\_  
 2-year school     4-year school     Other \_\_\_\_\_

College Major or Career Selection: \_\_\_\_\_

Financial Information:

Tuition: \_\_\_\_\_

Books: \_\_\_\_\_

Room & Board \_\_\_\_\_

Estimated Total Cost Per Semester: \_\_\_\_\_

On a separate sheet(s) list Extra-Curricular Activities, Volunteer Organizations, or Community Services you have participated in, as well as Awards or Honors you have received, during your High School and Post-High School years. PLEASE INCLUDE ANY SCHOLARSHIPS AND AMOUNTS IN YOUR LIST OF AWARDS.

(This information will be considered in judging character and motivation so please realize it is IMPORTANT to complete this, as well as all other requirements.)

**CASA GRANDE COMMUNITY HOSPITAL FOUNDATION  
SCHOLARSHIP APPLICATION  
PRIVACY ACT CONSENT FORM**

TO WHOM IT MAY CONCERN:

In accordance with the provisions of Public Law 93-579 (The Privacy Act of 1974). I hereby give my consent for information concerning my file to be furnished to members of the Casa Grande Regional Medical Center Auxiliary Scholarship Committee.

I/my dependents applied to Casa Grande Regional Medical Center Auxiliary for scholarship assistance and request that any relevant information that may be required in order to assist in responding to my inquiry be provided to them in accordance with the provisions of the law.

NAME (IN FULL): \_\_\_\_\_  
(please print)

COMPLETE ADDRESS (residence address and mailing address if different):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TELEPHONE: DAY \_\_\_\_\_ EVENING \_\_\_\_\_

STUDENT'S SIGNATURE: \_\_\_\_\_

STUDENT'S SOCIAL SECURITY NUMBER: \_\_\_\_\_

PARENT'S OR LEGAL GUARDIAN'S SIGNATURE: \_\_\_\_\_

PARENT'S OR LEGAL GUARDIAN'S SOCIAL SECURITY NUMBER: \_\_\_\_\_