

St. Johns County Medical Alliance College Scholarship Application

The St. Johns County Medical Alliance represents spouses of St. Johns County physicians. Its purpose is to promote health education, identify and address health-care needs and issues, participate in health-related legislation, and provide college scholarships to St. Johns County students.

The St. Johns County Medical Alliance College Scholarship Program is open to all St. Johns County graduating seniors pursuing an education in *pre-medicine, nursing, or allied health*.

Pre-medicine programs prepare people to attend medical school. **Nursing** programs prepare people to care for the sick, infirm, or disabled. **Allied health** programs prepare people to pursue occupations in direct patient care and support. **Allied health** professionals support, facilitate, and compliment the roles of doctors and nurses.

Selection Criteria

- Applicants should be St. Johns County graduating seniors pursuing an education in *pre-medicine, nursing, or allied health*.
- Applicants must reside in St. Johns County and plan to begin a program of study, in the fall, at an accredited four year college/university or a two year community college.
- Applications are evaluated by impartial members of the St. Johns County Medical Alliance College Scholarship Committee.
- Following the initial evaluation of applications, using a weighted point scale, semi-finalists are selected and asked to participate in an individual interview with members of the selection committee. Once the interviews are completed, finalists are selected and notified by mail or email. Typically, the Medical Alliance awards three scholarships each school year.
- Scholarship applicants are evaluated according to academic ability, school involvement, community service, and financial need.

Application Checklist

The application becomes valid when you complete the following four steps.

1. Include an official copy of your high school transcript.
2. Provide two letters of recommendation.
3. Submit an essay outlining your goals and aspirations (see page 6).
4. Complete the application, in full, pages 3 - 6.

Please note. Your application will be discarded if the four steps are not completed.

A copy of this application can also be found & printed from www.sjcma.blogspot.com.

The postmark deadline is the fourth Friday in March.

Applications should be returned to the following address:

St. Johns County Medical Alliance
c/o Flagler Hospital
400 Health Park Blvd.
St. Augustine, FL 32086

Please detach pages 1 and 2 and retain for your records. Please mail only pages 3 to 6. Thank you.

For Your Personal Records

Record the post marked date you mailed the application to the SJCMA.

Month

Day

Year

St. Johns County Medical Alliance College Scholarship Application

Personal Information

Name: _____
Last First Middle Initial

Mailing Address: _____
Street City State

Zip Code _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Date of Birth: _____
Month Day Year

Are you a resident of St. Johns County? Yes ___ No ___

Name of high school currently attending: _____

Pending graduation date: _____
Month Year

Name of university/college you will attend in the fall _____

City _____ State _____

Major or degree program _____

Specialty, if decided _____

Please check one: _____ Pre-Medicine _____ Nursing _____ Allied Health

Financial Information

Please indicate your family's adjusted gross income from last year's tax return. Please check one.

Under \$15,000 _____ \$15,000 to \$35,000 _____ \$35,000 to \$50,000 _____

\$50,000 to \$100,000 _____ Over \$100,000 _____

Mother's Name _____ Occupation _____

Father's Name _____ Occupation _____

Number of family members living at home _____ Number of Children _____

Ages of children _____

Number in college _____

Academic Information

This section to be completed by your guidance counselor.

Class Rank: Numerical Position _____ Percentile _____

Total number in class _____

GPA _____ Weighted GPA _____

Total community service hours (all four years) _____

Guidance counselor's name (please print) _____

Contact number _____

Email address _____

Signature _____

School Activities

List all school activities in which you have participated during the last 4 years (e.g. student government, music, sports, etc.) Use an extra sheet of paper, if needed.

Use the following format or your application will be discarded.

Activity time/week # of years Special Awards Position/Office

Community Service

List all of community service activities in which you have participated during the last four years (e.g. non-profit organizations, youth groups, etc.) Use an extra sheet of paper, if needed.

Use the following format or your application will be discarded.

Activity time/week # of years Special Awards Position/Office

Essay

On this page, write/type a brief essay (100-200 words) describing your goals as they relate to your future education and career. Use a separate piece of paper, if needed.

In conclusion, write two to three sentences, explaining any experiences or persons that have contributed to your achievements to date or have influenced you to pursue an education and career in healthcare.