

**CHEROKEE REGIONAL MEDICAL CENTER  
AUXILIARY SCHOLARSHIP**

The Cherokee Regional Medical Center Auxiliary awards scholarships annually to assist area students entering a health-related career.

The scholarships are in the amount of \$400. This amount must be repaid to the hospital auxiliary if the course of study is not completed or the recipient does not enter the school of choice by October 1 of the year the scholarship is received.

**The application deadline is April 1<sup>st</sup>.** Applications will be reviewed by Auxiliary members and a decision reached by late April. Scholarships will be presented to the recipients at the Cherokee Regional Medical Center's Annual May Coffee. If no applicants are qualified, the scholarship will not be awarded.

This scholarship is based on both financial need and overall high school performance.

**Student eligibility will be judged on the following:**

1. Applicant must be a **resident of the Cherokee Regional Medical Center Service Area.**
2. Applicant must be a high school senior in good standing.
3. Use of the scholarship is limited to studies relating to a **human health professional career.**
4. The need for financial assistance is a consideration of the committee.
5. Completed applications, including attachments and recommendations **must be submitted by April 1<sup>st</sup>.**

**Return to:**

**Cherokee Regional Medical Center  
Attn: Administration, Auxiliary Scholarship  
300 Sioux Valley Drive  
Cherokee, IA 51012**



**Please attach:**

1. A copy of your scholastic records showing class rank, ACT scores, GPA, and yearly classes and grades
2. An essay on "Why I am Entering a Health Career" (150 word minimum)
3. Three completed forms of recommendation
4. A billfold size picture of yourself

**Please let us know the best way to contact you:**

- Home Phone: \_\_\_\_\_
- Cell Phone: \_\_\_\_\_
- Email Address: \_\_\_\_\_

The above completed application is true and valid.

\_\_\_\_\_  
Signature of Applicant

I am in support of my son's/daughter's application.

\_\_\_\_\_  
Signature of Parent

**CHEROKEE REGIONAL MEDICAL CENTER  
AUXILIARY SCHOLARSHIP  
LETTER OF RECOMMENDATION**

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

Describe the capacity in which you have known this candidate:

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Comment on the candidate's strengths to be a successful health career professional:

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Add any additional information that you believe we would want to have in considering this candidate:

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Signature \_\_\_\_\_ Date \_\_\_\_\_

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Signature \_\_\_\_\_ Date \_\_\_\_\_