



Foundation of CVPH Medical Center

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To: Area High School Guidance Counselors

From: Michelle Senecal *MS*
Development Assistant

Date: January 12, 2009

Re: Healthcare Scholarships

The Auxiliary Scholarship Committee of the Foundation of the CVPH Medical Center is offering one \$1,000 scholarship at each of nine participating High Schools - a total of nine scholarships - to 2009 graduating seniors entering a **healthcare field such as nursing, physical therapy, occupational therapy, speech therapy, pharmacy, radiology school, etc.**

Enclosed are application forms to distribute to interested/eligible students. Scholarship applications need to be completed in their entirety and received by the Auxiliary Scholarship Committee no later than April 1, 2009. This year we are asking each student to write a 100 (minimum) word essay on why they wish to pursue a degree in the healthcare field and we are also asking for a copy of their high school transcript. Mail to:

Foundation of CVPH Medical Center
Attention: Auxiliary Scholarship Committee
75 Beekman Street
Plattsburgh, NY 12901

Thank you for your assistance in making these materials available.

The Foundation of CVPH Medical Center promotes support for high quality, accessible health care and health education to benefit the North Country community through its partnership with CVPH Medical Center.

Foundation of CVPH Medical Center, Inc.

75 Beekman Street Plattsburgh, New York 12901 518-562-7169 FAX 518-561-0881 www.cvph.org

**FOUNDATION OF THE CVPH MEDICAL CENTER
 AUXILIARY SCHOLARSHIP COMMITTEE
 HIGH SCHOOL HEALTHCARE SCHOLARSHIP APPLICATION FORM**

APPLICANT NAME	BIRTH DATE
HOME ADDRESS	HOME PHONE
HIGH SCHOOL CURRENTLY ATTENDING _____ GRADUATION DATE _____	
GUIDANCE COUNSELOR NAME _____	
GUIDANCE COUNSELING OFFICE PHONE # _____	
EDUCATIONAL INSTITUTION YOU WILL ATTEND: (LIST SCHOOL NAME & ADDRESS)	
PROGRAM OF STUDY	
COMMUNITY SERVICE/ORGANIZATIONS IN WHICH YOU HAVE PARTICIPATED DURING HIGH SCHOOL	
HAVE YOU PARTICIPATED IN THE JUNIOR VOLUNTEER PROGRAM AT CVPH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DO YOU HAVE RELATIVES WHO WORK AT CVPH?	
I AM RECEIVING FUNDS FROM OTHER SOURCES: <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, LIST SOURCE(S) AND AMOUNT(S)	
SIGNATURE OF APPLICANT	DATE
SIGNATURE OF GUIDANCE COUNSELOR	DATE
RETURN COMPLETED FORM TO: FOUNDATION OF CVPH MEDICAL CENTER AUXILIARY SCHOLARSHIP COMMITTEE 75 BEEKMAN STREET PLATTSBURGH, NY 12901	FOR OFFICE USE ONLY: COURSE COMPLETION VERIFICATION: <input type="checkbox"/> Yes <input type="checkbox"/> No BY: _____ DATE: _____ CHECK #: _____ CHECK DATE: _____ DELIVERED TO: _____