



ST. LUKE'S HOSPITAL AUXILIARY
SCHOLARSHIP APPLICATION
(See instructions)

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

PERMANENT ADDRESS: \_\_\_\_\_

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

St. Luke's Associate \_\_\_\_\_ Yes \_\_\_\_\_ No

Department \_\_\_\_\_ Position \_\_\_\_\_

Family Member, St. Luke's Associate \_\_\_\_\_ Yes \_\_\_\_\_ No

Relationship to family member \_\_\_\_\_

Name of family member \_\_\_\_\_ Department \_\_\_\_\_

APPLICANT INFORMATION:

High School Graduated \_\_\_\_\_ Date \_\_\_\_\_

Colleges Attended/Dates \_\_\_\_\_

Other Certifications/Dates \_\_\_\_\_

Name and address of college/graduate nursing program in which you are accepted or currently enrolled:

\_\_\_\_\_

Will be attending: Full time \_\_\_\_\_ Part time \_\_\_\_\_ Expected date of completion \_\_\_\_\_

AGREEMENT

In submitting this application, I verify that all statements and representations made are true to the best of my knowledge.

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

Applicant Current Contact Information: Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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