CHAMBERSBURG AREA HOSPITAL AUXILIARY
$1000 SCHOLARSHIP FOR *ADULT*

---

1 Student must live within the geographic area that WellSpan Chambersburg Hospital serves.

2. Student must enter a human healthcare-related field and must start classes within the year.

3. Student must complete application.

4. Each student will receive the Award for one year only.

5. The Award will be given in one lump sum.

6. Application must be post marked on or before April 3, 2023.

7. Two letters of recommendation must accompany application, excluding family members.

9. Application must include a current transcript.

10. Send application to:

Jacqui Wolfe
Chambersburg Area Hospital Auxiliary Scholarship Committee
527 Larkspur Lane
Chambersburg, PA 17202

CHAMBERSBURG AREA HOSPITAL AUXILIARY
$1000 SCHOLARSHIP APPLICATION FOR ADULT
ENTERING HUMAN HEALTHCARE FIELD

---

NAME _____ DATE OF BIRTH _____

ADDRESS _____ TELEPHONE NO. _____

_____

_____ EMAIL ADDRESS _____

HIGH SCHOOL _____ YEAR GRADUATED _____

COLLEGE _____ YEAR GRADUATED _____

==========

1. What field of human healthcare do you plan to enter? _____
   _____

2. List schools where you have applied for admission in the human healthcare field. _____
   _____
   _____
   _____

3. Have you been accepted? YES NO

   Name of School you plan to attend _____

   School Address: _____

   _____

   Student ID# _____

4. SINGLE MARRIED

   Parent(s) Address Spouse's Address

   _____ _____

   _____ _____

   _____ _____

5. Your Occupation _____ Spouse's Occupation _____

6. Number of children in family and their ages _____

   a. Their ages _____
   b. Number self-supporting: Totally _____ Partially _____
   c. Number in college, training school, or any schools other than elementary or secondary [middle, junior/senior high] schools

7. Describe any employment you have had and list any community service and amount of hours. _____
   _____
   _____
   _____
   _____

8. Write an explanation as to why this scholarship is needed and why you have chosen your selected field. _____
   _____
   _____

9. Statement of Financial Need by Applicant. **THIS INFORMATION WILL BE CONSIDERED CONFIDENTIAL BY THE COMMITTEE**.

   I certify that financial assistance is necessary for the applicant to enter and complete this human healthcare field.

   a. Your Present Employment _____ Annual Income _____

   b. Spouse's Employment _____ Annual Income _____

   c. Parent(s)' Employment _____ Annual Income _____
      (only if living with parents)

   d. Rent Home ☐ Own Home ☐

   e. List financial obligations.

   f. Circumstances limiting your earning ability

   _____
   Signature