# Western Kings Memorial Health Society

## Category: FINANCE

##  Scholarship Policy

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Western Kings Memorial Health Society Date

# WESTERN KINGS MEMORIAL HEALTH SOCIETY

# SCHOLARSHIP PROCEDURE

In recognition of its mission statement the Western Kings Memorial Health Society is offering two $1,000 scholarships for students pursuing a post-secondary education in the health care profession.

Purpose: To recognize and encourage students entering the health care and a related field such as physical education, fitness, and nutrition.

Requirements: A completed application form submitted with a letter of reference. The application will include a letter written by the applicant describing their future plans in the anticipated field and why they feel they are deserving of the scholarship.

Details and the application form can be obtained from:

Manager

Western Kings Memorial Health Society

P.O. Box 490, Berwick NS

B0P 1E0

mgr.wkmhs@bellaliant.com

902-538-0096

# WESTERN KINGS MEMORIAL HEALTH SOCIETY

# SCHOLARSHIP APPLICATION

# 2018

1. The applicant must be a Canadian Citizen or landed immigrant, enrolled in the second, third or fourth year of a minimum two-year health care or directly related program at a recognized institution. This can include health care and a related field such as physical education, fitness and nutrition.
2. The applicant or their parents or guardian must be a resident of Western Kings County.
3. Preference will be given to applicants who have performed in a volunteer capacity during the past two years.
4. The applicant must have completed the full first year of their designated program with a minimum average of 65%. (or equivalent) A copy of the transcript of grades will be required as well as a letter of reference.
5. The successful candidate(s) will be selected based on a) academic achievement b) essay and c) references.
6. Each applicant is required to submit a letter describing their future in his or her anticipated field and why they should be selected to receive the scholarship.
7. Two $1,000 scholarships are available each year. If a suitable recipient is not found in any given year the scholarship will not be awarded.

Application deadline:

The deadline for applications will be June 29, 2018

# WESTERN KINGS MEMORIAL HEALTH SOCIETY

# SCHOLARSHIP

# APPLICATION FORM

#### **Personal information:**

Name (last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (first and middle Initial) \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Civic address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

Town\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Postal code\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of residency in Nova Scotia: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

High school attended \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Year of graduation\_\_\_\_ \_\_\_

# EDUCATION INFORMATION (include a recent transcript)

#### **2017-2018 Academic Year**:

Indicate institution you attended: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of program enrolled in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

Year of program (circle): 1st 2nd 3rd 4th Other

#### **2018-2019 Academic Year:**

Indicate institution you are attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Name of program enrolled in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Year of program (circle): 1st 2nd 3rd 4th Other

Please explain how your program is related to our mission statement;

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# DECLARATION OF APPLICANT:

#### I HAVE READ AND UNDERSTAND THE INSTRUCTIONS, AND DECLARE THAT:

1. All information provided is true and complete and I understand it is subject to audit;
2. I will be a full-time student at the institution named for the period stated
3. I will immediately notify the Western Kings Memorial Health Society in writing if I withdraw from full-time studies before completing the semester of studies.

#### I UNDERSTAND AND AGREE THAT:

1. My personal information pertaining to my post-secondary academic record and enrolment may be released and exchanged by and between Western Kings Memorial Health Society and the educational intuition for determining my eligibility for a scholarship.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 Signature Date

# Western Kings Memorial Health Society

*Mission statement: To encourage and promote active treatment and primary health care through the use of our facility, while ensuring the financial stability of the Society for the residents of Western Kings County.*

# Letter of Reference

In support of the application of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Please indicate how long and under what circumstances you have known the above-named applicant:

### Explain why you believe this student is a worthy candidate for the Western Kings Memorial Health Society’s scholarship:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Use additional sheet if required)

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