SKYLINE HEALTH FOUNDATION

There is one application. Please select which scholarship you are applying for.

◯ The Brown Nursing Scholarship

Nursing Education

Applicants must meet the following criteria:

1. Must be a resident of the Columbia River Gorge. Skyline Health Employees are encouraged to apply.
2. Must have maintained a minimum GPA of 3.0 on a 4-point scale and/or supply a letter from your supervisor.
3. Must be seeking post-secondary education in the nursing field.
4. Must be dedicated to returning to the Skyline service area to work or volunteer for a period of at least one year, if such employment or service is available.
5. Scholarship can be used for educational tuition and books. The educational institution will return scholarship funds exceeding the qualified enrollment expenses to Skyline Health Foundation.
6. Scholarship should be used within one year.
7. Must be enrolled in a health care related course at the time scholarship is distributed.

◯ Wayne M. Henkle, MD Scholarship

Health Care Education (not nursing)

For nursing education please apply for The Brown Nursing Scholarship.

Applicants must meet the following criteria:

1. Must be a resident of the Skyline Health service area in Western Klickitat County or Skamania County or employee of Skyline Health. Employees are encouraged to apply.
2. Must have maintained a minimum GPA of 3.0 on a 4-point scale and/or supply a letter from your supervisor.
3. Must be seeking post-secondary education in the health care field (*Does not apply for nursing. For nursing education please apply for The Brown Nursing Scholarship*.)
4. Must be dedicated to returning to the Skyline service area to work or volunteer for a period of at least one year, if such employment or service is available.
5. Scholarship should be used within one year.
6. Must be enrolled in a health care related course at the time scholarship is distributed. Scholarship can be used for educational tuition and books. The educational institution will return scholarship funds exceeding the qualified enrollment expenses to Skyline Health Foundation.

Applications must be delivered or post-marked to Skyline Health Foundation by April 30 for consideration. Send your application to Skyline Health Foundation, PO Box 1625, White Salmon, WA 98672, email it to dnielson@myskylinehealth.org or drop it off at Skyline Health, 211 Skyline Dr., White Salmon, WA.

Payment will be made to the educational institution upon proof of enrollment. **The number of recipients, as well as the amount annually distributed is at the discretion of the Skyline Health Foundation Board of Directors.**

Skyline Health Foundation Scholarship Application

(Please print clearly)

I. PERSONAL DATA

Full Name _____ Date of Birth _____

Mailing Address _____ City, State, Zip Code _____

Home Phone _____ Email _____

Employer_____ Occupation _____

Address _____ Full-time or Part-time _____

List names and ages of dependents:

_____

List your community, educational and organizational activities and note any honors or achievements:

_____

_____

Briefly state your career, academic and/or personal goals:

_____

_____

Describe your work experience:

_____

_____

If you know any employee of Skyline Health and or any member of Skyline Health Foundation, please provide their names and describe any relationship:

_____

_____

II. EDUCATIONAL DATA

High School _____ City, State _____

Year Graduated _____ GPA _____ If GED date/place completed _____

Colleges/Universities attended:

_____

_____

Number of Credits Earned to Date _____ Current GPA _____

College/School you will be attending _____

Term that the Scholarship is being applied for _____ Year _____

III. FINANCIAL INFORMATION

Have you received previous scholarships from Skyline Health Foundation? □ Yes □ No

If yes, specify amount and purpose:

_____

Have you applied for other scholarships or financial aid: □ Yes □ No

If yes, describe: _____

Is it necessary that you work in order to attend school? □ Yes □ No

Briefly provide any additional financial, personal or professional information, which may help us determine need or merit in making a scholarship available to you.

_____

_____

Describe any skills that might be used in service to Skyline Health or other health care provider in our service area.

_____

_____

Should a scholarship be awarded to you, would you be willing to commit a specified amount of time to Skyline Health at the conclusion of your education?

_____

IV. EDUCATIONAL GOALS

COURSE #	SECTION #	COURSE TITLE	CREDITS

Briefly explain your reasons for taking the course(s)

_____

_____

_____

V. REFERENCES (Please attach letter(s) of recommendation from an appropriate agency or individual.)

Name _____ Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

The undersigned applicant hereby authorizes Skyline Health Foundation to contact parties named herein and to verify all information submitted.

I certify all statements and information furnished are true and complete.

Signed _____ Date _____