OSF
SAINT ELIZABETH
MEDICAL CENTER

OSF SAINT ELIZABETH MEDICAL CENTER
EDUCATIONAL ASSISTANCE PROGRAM FOR HEALTH CAREERS
APPLICATION INFORMATION

General Information

The program supports outstanding high school seniors and college students living in LaSalle County pursuing advanced degrees in a human health sciences related field.

This financial assistance is open to graduating high school seniors planning to attend a college of higher education or college students enrolled in an accredited college or university, whose primary residence is in LaSalle County or a surrounding community served by OSF Saint Elizabeth Medical Center. Employees of OSF Saint Elizabeth seeking a degree in a healthcare field may also apply.

The amount awarded can be up to $5,000 annually and must be applied toward tuition and fees and will be paid directly to the college or university. The OSF Saint Elizabeth Education Support Program Committee will determine the number of students that will receive financial assistance and the amount each will receive based on the following criteria:

- **Educational Achievement:** Attach an official copy of your most current transcript from your latest academic year. A minimum cumulative G.P.A. of 2.75 out of 4.0 or 3.5 out of 5.0 is required.
- **Financial Need**: Include information on the application pertaining to other sources of educational assistance. If applicable, please include FAFSA results with the application.
- **Essay Content (for High School Students only):** Include a short essay (one page only/350 words) as requested in the application.
- **Letters of Recommendation:** Attach **two** academic letters of recommendation (forms included) attesting to your academic achievement, goals and character, as well as **two** former employer character reference letter. All four (4) letters are to be signed, dated and handled as instructed on page #5 of your application.

Please mail your completed application and requested documentation by **March 31, 2017** to:

OSF Saint Elizabeth Medical Center
Attn: Education Support Program Committee / HR
1100 E. Norris Drive
Ottawa, IL 61350

You may also email your application and documents to amy.l.gross@osfhealthcare.org

Please contact the OSF Saint Elizabeth Human Resources department at (815) 431-5318 if you have any questions.

Please read the following carefully.

Student Eligibility

The applicant must complete and submit to the OSF Saint Elizabeth Human Resources office an **EDUCATIONAL ASSISTANCE PROGRAM FOR HEALTH CAREERS APPLICATION**.
The application must include:

a) current high school/college transcript
b) a written letter of release permitting the selection committee to review the student's academic, clinical and extracurricular records
c) a summary of significant academic and curricular achievements at the college or in the community with a listing of references
d) a brief statement of educational goals, as outlined in the application.

Awarding or denying financial assistance will be based, among other things, upon ACT, SAT or an equivalent college entrance exam, high school record, social and community activities, volunteerism, previous high school/college records, personal references and one page essay. Include work history of present employer, if applicable.

Minimum requirements for consideration of financial assistance include:

a) currently enrolled or accepted in an accredited school or college, for the degree they are seeking to attain.
b) cumulative G.P.A. of 2.75 out of 4.0 or 3.5 out of 5.0.
c) two (2) favorable academic letters of recommendation (forms included)
d) two (2) favorable letter of recommendation from a non-family member attesting to your achievements, character and goals
e) Student agrees to work or continue to work at OSF Saint Elizabeth Medical Center for the required time frame.

Key factors in determining awards will be an interview with a committee of OSF Saint Elizabeth Medical Center and the review of application and required supporting documents as outlined in this application. All decisions are final.

OBLIGATIONS - WHAT THE APPLICANT AGREES TO:

The applicant hereby agrees to employment with OSF Saint Elizabeth Medical Center for a minimum commitment period of one (1) year. If working full-time or part-time, the applicant would be committed to work 2,080 hours for awards received up to $2,500. If expense dollars exceed $2,500, a commitment period would continue until the applicant has worked 2,080 hours for each $2,500 awarded. This obligation is in effect after receiving an offer of employment from OSF Saint Elizabeth Medical Center. The commitment period will commence 90 days after the individual's start date with OSF Saint Elizabeth Medical Center. If the individual is a new graduate or has not received their registry or certification, the commitment begins when it is received.

If a student fails to complete the educational program covered under this Agreement, the student must notify the Human Resources Department within seven (7) calendar days of such failure and repay the entire amount paid by the OSF Saint Elizabeth Medical Center immediately. The applicant agrees to pay legal and other costs incurred by the OSF Saint Elizabeth Medical Center in enforcing this Agreement.

The student must submit his/her grades at the end of each semester to the Human Resources Department for committee review. If a recipient changes from full-time to part-time student status, he/she is to contact Human Resources as soon as possible. If a student drops or fails a course during the period of the educational assistance, or fails to maintain the required cumulative G.P.A., the student will not receive any additional funding beyond that specified in the Agreement, and at the sole discretion of OSF Saint Elizabeth Medical Center, the student may be required to satisfy the obligations set forth in Paragraph 1 under "Obligations-What The Applicant Agrees to" within 60 days of the subsequent graduation date or repay the amount awarded within 30 days.

OSF Saint Elizabeth Medical Center, 1100 E. Norris Drive, Ottawa, IL 61350
(815) 433-3100 www.osfsaintelizabeth.org

OSF
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EDUCATIONAL ASSISTANCE PROGRAM FOR HEALTH CAREERS
APPLICATION

1. Full Name: _____

2. Present Address: _____ Phone # _____

_____ Cell # _____

3. Permanent Address & Phone #(☐ same as above): _____

_____

4. Date of Birth: _____ Social Security #: _____

5. Marital Status: _____ 6. Spouse's Name: _____

7. Dependents (*Name, age and relationship*): _____

_____

8. What is your professional occupational goal: _____

_____

9. What school will you attend this fall: _____

_____

10. Full-time or Part-time: _____ 11. Expected Graduation Date: _____

12. If part-time, specify what else you will be doing: _____

_____

13. Residence Plans: *Dormitory*_____ *Home*_____ *Other* (Specify)_____

14. What is your course of study: _____

15. What is your expected academic level as of September _____

16. What is your cumulative grade point average: _____

17. If a college undergraduate, what major, if any, have you declared: _____

_____

18. Have you taken post-high school study in a field other than that which you will be in this fall? If so, what course(s) and how do you explain your change of interest: _____

19. Have you applied for or will you be receiving other financial awards/scholarships/grants for the next year? If yes, please explain:

20. What particular qualifications do you feel you have for the occupation you have chosen? When did you decide on this field, and what were some of the factors which led to your decision: _____

21. Discuss how OSF Saint Elizabeth Medical Center has benefited your family or you: _____

22. Please explain how you see yourself contributing to the future of healthcare in your local community:

23. **Personal Essay (for High School Students only).** Essay should be approximately 350 words, well developed and focused on your motivation for a healthcare career. Briefly state your long-term education professional goals and discuss your most challenging, exciting or enriching intellectual experience.

Please type your essay on 8½" x 11" paper and attach to this application.
Be certain to identify it with your name and Item #23.

24. **Letters of Recommendation:** List the names and addresses of the **four (4)** persons who are writing your letters of recommendation. **Two (2)** must be academic letters of recommendation (forms included) attesting to your academic achievement, goals and character. **Two (2)** must be a non-family character reference letter; i.e. a former employer. Each recommendation must be submitted in a sealed envelope with the writer's signature written across the flap. We require these letters be submitted along with your application.

Academic Reference _____

Address: _____

Academic Reference _____

Address: _____

Former Employer Reference _____

Address: _____

Former Employer Reference _____

Address: _____

Information in this section regarding FAMILY need not be completed if you are completely self-supporting.

1. Father's Name: _____

   Father's occupation and approximate income: _____

   _____

2. Mother's Name: _____

   Mother's occupation and approximate income: _____

   _____

3. If married, spouse's occupation and approximate income: _____

   _____

4. Number and ages of any siblings/dependents: _____

5. How many siblings in school: _____ 6. Of these, how many in college: _____

7. Are there any other members of your family in college: _____

8. Do you contribute to the support of any person(s) or have other financial obligations? If so, explain. (Example: current education/student loans – amount and when due.) _____

9. List in chronological order all schools attended beyond elementary school (with addresses and degrees or diplomas obtained). _____

10. What honors, academic or otherwise, have you received and when: _____

11. In what health or science-related fields or activities have you been involved, either for recreation, as a volunteer or an employee: _____

12. Below, list your resources and your anticipated expenses for the coming school year.

RESOURCES (estimated per academic year)		**EXPENSES** (estimated per academic year)	
Parents	$_____	Tuition & Fees	$_____
Friends/Relatives	$_____	Room	$_____
Personal Savings	$_____	Board	$_____
Employment	$_____	Books & Supplies	$_____
Loans	$_____	Transportation	$_____
Other *	$_____	Personal & Other	$_____
TOTAL	**$**_____	**TOTAL**	**$**_____

13. List other financial awards, scholarships, grants, FAFSA, etc. that you have received or applied for:

SCHOLARSHIP, GRANT, ETC.	**DATE/AMOUNT RECEIVED**	**DATE/AMOUNT APPLIED FOR**

AS PART OF YOUR APPLICATION, PLEASE REMEMBER TO SUBMIT THE FOLLOWING:	
1)	**Two** academic letters of recommendation (forms included) attesting to your academic achievement, goals and character, as well as **two** former employers reference letters (forms included). Each recommendation must be submitted in the enclosed envelope with the writer's signature written across the flap.

2)	Written **essay (for HS Students)** profiling yourself stressing factors relevant to your occupational choice and goals, qualifications, and motivation you have to pursue your education for your chosen profession as outlined in the application under Line 23 in the first section of this application. Limit it to one 8½" x 11" type-written page (350 words).
3)	**An official high school and/or college transcript**. *High school transcript needed only if you are entering freshman year or first year of a hospital-based program*. Schools must send information directly to OSF Saint Elizabeth Medical Center, Human Resources, 1100 E. Norris Drive, Ottawa, IL 61350
4)	**Official proof of acceptance** (if not currently enrolled) from the educational institution you will attend.

Contact OSF Saint Elizabeth Medical Center Human Resources at 815-431-5318 if you have any questions. Application and supporting documents for the Funds must be received by

March 31, 2017.

Applications for other Financial Assistance will be considered at any time.

CONSENT FOR RELEASE OF INFORMATION

"I hereby consent to the release of any information in connection with the foregoing that in the sole judgment of the OSF Saint Elizabeth Medical Center may be of assistance in evaluating my application. I hereby waive any confidentiality with respect to such information insofar as the OSF Saint Elizabeth Medical Center is concerned, since it is my understanding that the information will be used solely for the evaluation of my application and for no other purpose. The information on this form is, to the best of my knowledge, complete and valid. Any false statement would be cause for termination of any funding. I firmly plan to complete my intended course of study. If I receive an award, I give consent to use my name and photo for publicity purposes."

Signature of Applicant _____

Date Completed _____

ONLY RECIPIENTS WILL BE NOTIFIED

Rev. 2/2017

ACADEMIC LETTER OF RECOMMENDATION

TO BE COMPLETED BY THE STUDENT:

NAME OF APPLICANT:_____ **STUDENT #:**_____

FACULTY NAME:_____ **DATE:**_____

SCHOOL:_____

MAILING ADDRESS:_____

_____

I AM APPLYING FOR: OSF SAINT ELIZABETH MEDICAL CENTER EDUCATIONAL ASSISTANCE PROGRAM FOR HEALTH CAREERS

I grant permission for the authorities of OSF Saint Elizabeth Medical Center to investigate my references and release said Medical Center and my (former) instructor from any and all liabilities resulting from such investigation.

_____ _____

APPLICANT'S SIGNATURE **DATE**

TO BE COMPLETED BY THE FACULTY MEMBER:

If there is any information which you would prefer discussing personally, you may call Human Resources at (815) 431-5318. Please use the boxes below to indicate your assessment of the Student's abilities.

TRAIT	SUPERIOR	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	NO OPPORT. TO OBSERVE
PERFORMANCE: Carries out assigned tasks promptly, independently & thoroughly, persevering, industrious.					
ORIGINALITY: Demonstrates initiative and resourcefulness, uses imagination and is not stereotyped in thinking.					
JUDGMENT: Critically & reliably evaluates facts (people, policies, situations), uses common sense.					
WRITTEN/ORAL EXPRESSION: Expresses self well orally & in writing.					
DEVELOPMENT POTENTIAL: Has potential for personal & professional growth.					
LEADERSHIP: Capacity to assume responsibility, organize work & harmoniously execute a project with others.					
ADAPTABILITY: Ability to evaluate new or changing conditions & accept them naturally.					

Total number of class days missed _____ Total number of clinical days missed _____

Student was/is in his/her Freshman_____ Sophomore _____ Junior _____ Senior_____ year when he/she was in my class.
(Please check all that are applicable.)

Clinical Rotation Course:_____

_____ _____

FACULTY MEMBER'S SIGNATURE **DATE**

ACADEMIC LETTER OF RECOMMENDATION

TO BE COMPLETED BY THE STUDENT:

NAME OF APPLICANT:_____ **STUDENT #:**_____

FACULTY NAME:_____ **DATE:**_____

SCHOOL:_____

MAILING ADDRESS:_____

_____

I AM APPLYING FOR: OSF SAINT ELIZABETH MEDICAL CENTER EDUCATIONAL ASSISTANCE PROGRAM FOR HEALTH CAREERS

I grant permission for the authorities of OSF Saint Elizabeth Medical Center to investigate my references and release said Medical Center and my (former) instructor from any and all liabilities resulting from such investigation.

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Total number of class days missed _____ Total number of clinical days missed _____

Student was/is in his/her Freshman_____ Sophomore _____ Junior _____ Senior_____ year when he/she was in my class.
(Please check all that are applicable.)

Clinical Rotation Course:_____

_____ _____

FACULTY MEMBER'S SIGNATURE **DATE**

EMPLOYER LETTER OF RECOMMENDATION

TO BE COMPLETED BY THE STUDENT:

NAME OF PERSON COMPLETING REFERRAL:_____ **DATE**_____

NAME OF BUSINESS:_____

ADDRESS:_____

NAME OF APPLICANT_____

I AM APPLYING FOR: OSF SAINT ELIZABETH MEDICAL CENTER EDUCATIONAL ASSISTANCE PROGRAM FOR HEALTH CAREERS

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_____ _____

APPLICANT'S SIGNATURE **DATE**

TO BE COMPLETED BY THE EMPLOYER:

If there is any information which you would prefer discussing personally, you may call Human Resources at (815) 431-5318. Please use the boxes below to indicate your assessment of the Student's abilities.

POSITION HELD:_____ **FULL TIME:**_____ **PART TIME:**_____

DATES OF EMPLOYMENT :From:_____ **to** _____

REASON FOR LEAVING:_____

	EXCELLENT	GOOD	SATISFACTORY	UNSATISFACTORY	REMARKS
Quality of Work					
Quantity of Work					
Attendance & Punctuality					
Attitude					
Responsibility					
Communicative Ability (Oral & Written)					
Overall Rating					

WOULD YOU RE-EMPLOY: YES:_____ **NO:**_____ **EXPLANATION:**_____

_____

_____

ADDITIONAL COMMENTS:_____

_____

_____

_____

_____ _____

SIGNATURE/TITLE **DATE**

EMPLOYER LETTER OF RECOMMENDATION

TO BE COMPLETED BY THE STUDENT:

NAME OF PERSON COMPLETING REFERRAL:_____ **DATE**_____

NAME OF BUSINESS:_____

ADDRESS:_____

NAME OF APPLICANT_____

I AM APPLYING FOR: OSF SAINT ELIZABETH MEDICAL CENTER EDUCATIONAL ASSISTANCE PROGRAM FOR HEALTH CAREERS

I grant permission for the authorities of OSF Saint Elizabeth Medical Center to investigate my references and release said Medical Center and my (former) instructor from any and all liabilities resulting from such investigation.

_____ _____

APPLICANT'S SIGNATURE **DATE**

TO BE COMPLETED BY THE EMPLOYER:

If there is any information which you would prefer discussing personally, you may call Human Resources at (815) 431-5318. Please use the boxes below to indicate your assessment of the Student's abilities.

POSITION HELD:_____ **FULL TIME:**_____ **PART TIME:**_____

DATES OF EMPLOYMENT :From:_____ **to** _____

REASON FOR LEAVING:_____

	EXCELLENT	GOOD	SATISFACTORY	UNSATISFACTORY	REMARKS
Quality of Work					
Quantity of Work					
Attendance & Punctuality					
Attitude					
Responsibility					
Communicative Ability (Oral & Written)					
Overall Rating					

WOULD YOU RE-EMPLOY: YES:_____ **NO:**_____ **EXPLANATION:**_____

_____

_____

ADDITIONAL COMMENTS:_____

_____

_____

_____

_____ _____

SIGNATURE/TITLE **DATE**