PCMC Volunteers Inc.

Graduating High School Seniors

Purpose:
To assist graduating high school seniors who meet the standards and qualifications set forth below and who wish to advance in or enter into an accredited healthcare field. This field would include, but is not limited to, Certified Nursing Assistants, LPN's, RN's, Physical Therapists, Respiratory Therapists, Radiology Techs, Pharmacy Techs, Lab Techs, etc. Those applicants not pursuing a direct patient care field who wish to enter an accredited healthcare-related curriculum may apply, and will be considered.

Standards and Qualifications

1. To be considered for a Volunteer Services Scholarship students must complete the scholarship application and include a cover letter explaining their career goals and the reason financial aid is being sought.
2. Applicant must provide proof of current participation or acceptance in an approved collegiate or technical program with an intent to pursue a future in an accredited health care field
3. Applicant must be a graduating senior.
4. Applicants must have at least 100 volunteer hours and they must be civic or community based in nature.
5. All applicants must provide a scholastic record indicating a GPA of 3.0, B, or passing.
6. Applicant must provide two letters of recommendation from leaders in the community.
7. A 500 word essay on the importance of Volunteerism.

   Please return the above items to the below address prior to the July, 20, 2018 deadline;

   Putnam Community Medical Center
   Attention Volunteer Services
   611 Zeagler Dr.
   Palatka, FL 32177

8. Two $500.00 scholarships will be awarded based on the **need for financial aid**, and the potential future contribution to healthcare, the letters of recommendation, and the perception that the applicant is a role model for patient care, and customer service to **Putnam County.**
9. Selections will be made without discrimination as to race, sex, creed, age, or national origin. Applicants must be citizens of the United States.

All information gathered on the applicant will be kept in strict confidence by the members of the Scholarship Committee and Human Resources. All questions should be directed to the Volunteer Coordinator at (386) 326-8071 or rose.bellamy@hcahealthcare.com

Name: _____ Date of Birth: _____

Full Address: _____

Telephone: (home) _____ (cell) _____ (other) _____

Email address: _____

Parent or Legal Guardian: _____ Phone: _____

When is best time to contact you? _____

What is your preferred method of contact? _____

EDUCATION INFORMATION

School Attending: _____ Grade Level: _____

Guidance Counselor: _____ Phone: _____

Have you ever been a PCMC Jr. Volunteer? If so when? _____

SKILLS, ACTIVITIES AND WORK EXPERIENCE:

Special Skills and Talents: _____

_____

School Activities and Awards

_____

_____

Volunteer Experience:

_____

_____

Interests:

_____

Languages:

_____

_____

CURRENT /FUTURE COLLEGE or TECHNICAL SCHOOL

Accredited Health Care Program: *Proof of enrollment is required with the application

Name of School: _____

Full Address: _____

Present Status: application accepted ____ presently attending ____ course completed ____

Applicant Signature: _____ Date: _____

Terms & Conditions

Applicants for and recipients of scholarships granted by Putnam Community Medical Center's Volunteer Services agree to the following terms and conditions:

1. The applicant understands that the Scholarship Committee will have access to all information contained in the PCMC employment/volunteer application file as developed and maintained by the Human Resources Department. It is further understood that the right of the Scholarship Committee to access Personnel information will cease as soon as a final decision has been made regarding the Scholarship Application.
2. It is understood that the scholarship money is to be used to assist with expenses incurred by the applicant during his/her transition from student to practitioner or to assist with expenses involved in continuing education.
3. A recipient is eligible to apply for an adult scholarship after one year following the initial payout and after acceptance into an accredited health care program.
4. The responsibility of administering this scholarship program shall rest with the Scholarship Committee and their decision shall be final.

I have read, understand and agree to the conditions of this Scholarship Agreement.

_____ _____
Applicant's Signature Date

_____ _____
Witness Date

To be completed by the Scholarship Committee:

Scholarship Approved: _____ _____
Date Committee Chairperson

Funds Distributed: _____ _____ Check No. _____
Date Volunteer Treasurer