Auxiliary of Warren Memorial Hospital

VolunTeen Scholarship Program

Purpose

The Auxiliary of Warren Memorial Hospital offers a scholarship program to Volun Teens that have volunteered for a minimum of 100 hours of service, and are a senior in High School. The purpose is to aid the recipient in furthering their education.

Qualifications

Please read carefully and comply with all information requested:

1. Deadline for Submission: Last Friday in March.
2. You must be a High School Senior.
3. Accepted to an accredited College, University or Vocational School.
4. A former or Current VolunTeen with Warren Memorial Hospital, volunteering for a minimum of 100 hours of service.
5. All documentation of requested information must be attached to the application.
6. The amount of the scholarship may vary from year to year with the minimum being $500.00.
7. Applications, submitted from schools in Warren County, are to be returned to your Guidance Department or the appropriate person within your school. Applicants not within Warren County should return their application to The Auxiliary of WMH Scholarship Committee. Warren Memorial Hospital. 1000 North Shenandoah Avenue Front Royal, VA 22630. A copy of your transcripts must accompany this application.
8. Provide a one page essay telling why you think you should be a recipient of this Scholarship.

Selection Process and Criteria

The criteria that are used to select recipients for scholarships are as follows: academic performance, active in school/community, number of hours served as VolunTeen; financial need is a consideration providing all other criteria is met.

The Selection Committee (Scholarship Committee) is comprised of three individuals, One (1) board Member, and two (2) from the auxiliary membership.

Terms of Scholarship

Scholarships that are awarded, the monies are sent to the College, University or Vocational School. Should a student fail to attend the College, University or Vocational School, the monies are returned to the Auxiliary of Warren Memorial Hospital.
VolunTeen Scholarship Application
Given by the Auxiliary of Warren Memorial Hospital

Name:_______________________________________________ Age:___________________
Address:____________________________________________ Telephone:________________
High School:________________________________________ Graduation Date:____________

Parent/Guardian Name:__________________________________________________________
Address:______________________________________________________________________
Telephone (Home):___________________________Work:_____________________________

What years did you volunteer at WMH?___________________________________________

College, University or Vocational School you have applied to:

________________________________________ Applied (  ) Accepted (  )
________________________________________ Applied (  ) Accepted (  )

FINANCIAL NEED: Are there any unusual circumstances concerning your family and/or financial
situation that you would like to bring to the attention of the scholarship committee? (Attach separate
sheet if necessary)

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

List any relationship(s) that you have with a member of the Auxiliary or Hospital Employee
_____________________________________________________________________________________
_____________________________________________________________________________________

Provide two references (not family members, not hospital employees or volunteers. Include at least one
teacher.)

Name:______________________________________________ Telephone:____________________
Address:___________________________________________________________________________

Name: _____________________________________________ Telephone: _____________________
Address: ________________________________________________________________

School/Community Activities: ________________________________________________

__________________________________________________________________________

__________________________________________________________________________

I certify that all of the information contained in this application is correct to the best of my/our knowledge and I give my consent to release the information of this application for the review of the Auxiliary of Warren Memorial Hospital Scholarship Committee

Student Signature_________________________________________ Date __________

Parent/Guardian Signature____________________________________ Date __________

Please return completed application form, and essay to
Auxiliary of Warren Memorial Hospital
Attn: VolunTeen Scholarship Committee
1000 Shenandoah Avenue Front Royal, Va. 22630
Or to the Guidance Department if you attend Warren County High School or Skyline High School