Sutter Health

Mills-Peninsula Medical Center Volunteer Services and Foundation Scholarship

Instructions and Required Documents

Only complete applications will be considered.

Submit all items at the same time. Use the checklist below to ensure that all items are included:

- ☐ Scholarship application with signed certification.
- ☐ Personal statement, including career goals and aspirations. Please include any hardship information and explain any discrepancies between the application and other official documents, such as Tax Form 1040.
- ☐ Official transcripts from an accredited college/university for the last two years of college that you attended. Unofficial or online transcripts must display student name, school name, grades and credit hours for each course and term in which each course was taken.
- ☐ Two letters of recommendation. Must be signed and on letterhead, if applicable.
- ☐ Federal Tax Return (Form 1040: first two pages only). Prior Year 1040 acceptable if current year is not available. If not self-supporting, parent's/guardian's/other's Form 1040 required. Be sure to **remove your Social Security number on your Tax Form.**
- ☐ Mills-Peninsula Medical Center employees only: Include your most recent performance evaluation.

Submit no later than May 15 to:

MPMC Volunteer Services Scholarship Program
1501 Trousdale Drive, Room 5100
Burlingame, CA 94010

For questions regarding the application process,
email MPHSVolunteerServices@sutterhealth.org or leave a message on the scholarship phone line: (650) 696-2465 Option 1. (MPMC Volunteer Services Office).

MPMC VOLUNTEER SERVICES/FOUNDATION FINANCIAL AID SCHOLARSHIP PROGRAM

Personal Information (Please type or print clearly)

Last Name: _____First Name: _____

Mailing Address: _____

City: _____State: _____Zip: _____

Cell Phone: (__ __ __) -_____- _____ Home phone: (_____)-_____-_____

E-Mail Address: _____

Birth Date: _____/__ __/__ __ __ __ Age: _____ Gender: _____
MONTH DAY YEAR

Are you: Single: ☐ Married: ☐

Do you have dependents? Yes ☐ No ☐ If yes, how many? _____Ages: _____

Are you and/or a family member a Physician and/or advanced practice provider who may make referrals to MPMC? Yes ☐ No ☐ If yes, name of Physician and/or advanced practice provider? _____

Employment/Work Experience

Name of Employer (Most Recent First)	Job Title	Dates of Employment	Hours/Week

Community Service

Organization (Most Recent First)	Dates	Hours/Week

Academic Information

List High School/College/Universities Attended (Most Recent First)	Dates of Attendance	Degree/Units Earned	GPA	GPA Scale

Current Career Goal (PT, OT, RN, MSN, etc.): _____Degree:_____

Are you enrolled in, or have you been accepted to a health care career or support program? Yes ☐ No ☐

Accredited College or University you are or will be attending: _____

Address of College/University: _____

City: _____ State: _____ Zip: _____

Will you be attending: Full Time ☐ Part Time ☐ Expected date of graduation: _____

Student ID at University you will be attending: _____

Financial Information

The following information is required to determine how you will fund the upcoming school year.

If your expenses are more than your income, please explain: _____

_____

List **expenses** you expect to incur for the **ENTIRE** academic year:

Expense Item	Comments	Cost
Tuition/Fees:		
Books/Supplies:		
Room/Board:		
Other Expenses:		
	Total:	

Will you be receiving financial aid? Yes ☐ No ☐

Please list **ALL** funding sources:

Funding Sources for Upcoming Academic School Year	Source	Amount
Applicant Contribution:		
Family Contributions:		
Grants:		
Scholarships:		
Loans:		
Other Financial Resources:		
Special Financial Circumstances to be considered:		
	Total:	

Please list **ALL** sources of income and that of **ANYONE** supporting you:

Name	Occupation	Dates of Employment	Annual Gross Income
Applicant:			
Mother:			
Father:			
Spouse:			
Other:			
		Total:	

Applicant's Certification

1. I understand that the information provided above is used for scholarship award eligibility and selection only.
2. I affirm that the information provided within is true, complete, and accurate, and that any award may be revoked without appeal if the information is found to be otherwise.
3. I am a resident of San Mateo County: Yes ☐ No ☐
4. I am a Mills-Peninsula Medical Center employee: Yes ☐ No ☐
5. I have received a previous Mills-Peninsula Volunteer Services and Foundation Scholarship: Yes ☐ No ☐
   a. If yes, what year? _____ and what amount? _____
6. Signature of Applicant _____ Date _____

Personal Statement:

Please explain your career goals and aspiration. Use 12p font and one (1) page only.