



*Improving Health. Saving Lives.*

## **Hospital Auxiliary Volunteers' Scholarship Program Application**

We are very pleased that you have chosen to submit an application for a scholarship from the Singing River Health System Auxiliary Volunteers. **Applicants must be enrolled or planning to enroll in a medical field of study.** Applications will be reviewed and judged on completion, GPA, transcripts, and narratives.

Please provide **all information** requested and mail your application to:

Singing River Health System  
Guest Relations Dept., Attn: Scholarship Committee  
2809 Denny Ave.  
Pascagoula, MS 39581

Applications will also be accepted in person at the Information Desk at Singing River Gulfport, Ocean Springs Hospital, or Pascagoula Hospital.

**Applications must be received by April 1 of the award year.**

Please make sure you include the following with your application:

- \_\_\_\_ Official ***certified and sealed*** transcripts from your school
- \_\_\_\_ Publishable picture (3" X 5" approximate size)
- \_\_\_\_ Letter from the school where you have been accepted or proof of current enrollment.

Recipients of the scholarships will be notified by mail and phone. We thank you for applying and wish you all the best in pursuing your degree and a career in healthcare.

[SingingRiverHealthSystem.com](http://SingingRiverHealthSystem.com)

### **Gulfport**

15200 Community Road  
Gulfport, MS 39503  
(228) 575-7000

### **Ocean Springs**

3109 Bienville Boulevard  
Ocean Springs, MS 39564  
(228) 818-1111

### **Pascagoula**

2809 Denny Avenue  
Pascagoula, MS 39581  
(228) 809-5000



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Singing River Health System Hospital Auxiliary Scholarship Application

Application Information (Type or print clearly):

Full Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ (home) \_\_\_\_\_ (cell)

Birth date: \_\_\_\_\_ SSN: \_\_\_\_\_

Are you employed by the Singing River Health System? (Y/N) \_\_\_\_\_

If yes, where? \_\_\_\_\_

Are you related to an employee of Singing River Health System? (Y/N) \_\_\_\_\_

If yes, what is the relationship and the name of the employee? \_\_\_\_\_

High School Attended: \_\_\_\_\_ Year Grad: \_\_\_\_\_

Awards:/Honors: \_\_\_\_\_

Are you attending a college/university at this time? (Y/N) \_\_\_\_\_

If yes, name of Institution: \_\_\_\_\_

GPA: \_\_\_\_\_ Hrs completed: \_\_\_\_\_

If not currently attending, what college/university do you plan to attend?

Field of study: \_\_\_\_\_ Date you expect to graduate: \_\_\_\_\_

Enrollment: Full-time \_\_\_\_ Part-time \_\_\_\_

Are you currently enrolled in or have you been accepted into a program in the medical field? (Y/N) \_\_\_\_\_

Name of school and program: \_\_\_\_\_

NOTE: YOU MUST ATTACH A SEALED CERTIFIED COPY OF YOUR MOST RECENT TRANSCRIPT(S) FROM YOUR HIGH SCHOOL AND / OR UNIVERSITY.

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(Use additional sheets to list any information if needed)

Other education:	Year(s) attended:	Graduated/Degree?
_____	_____	_____
_____	_____	_____

Please list the following:

Accomplishments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Community Activities/Involvement: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Activities/Awards: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Plans for the Future: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional information that would help us to know you better: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I (We) certify that the information contained in this application is correct and complete. I (We) further agree to provide, if requested, any other official documentation necessary to verify information reported. I (We) also understand that the award of the scholarship is contingent upon registration of classes for the Fall term. In the event I (we) cannot attend the Fall term, I (we) will return all scholarship money.

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date

And/or

\_\_\_\_\_  
Parent's signature

\_\_\_\_\_  
Date

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