Canton-Inwood Area Health Foundation
2023 Health Care of Tomorrow Scholarship Program

The mission of Canton-Inwood Area Health Foundation is to *inspire and engage philanthropic support for Sanford Canton-Inwood to improve the health and wellness of our communities*. Those philanthropic resources are provided to worthy projects and individuals best illustrating Foundation ideals while fulfilling the health needs of the future.

Canton-Inwood Area Health Foundation has developed a scholarship program to assist students who are pursuing or planning to pursue a health care degree at a post-secondary two or four-year college, university or vocational-technical program. The scholarships will be offered on a yearly basis for full-time study at any accredited post-secondary institution the student chooses.

The scholarship program is administered by the Canton-Inwood Area Health Foundation. Canton-Inwood Area Health Foundation believes in equal opportunity and will grant scholarships without regard to race, color, creed, religion, gender, disability, national origin or any other category protected by state, local or federal law, regulation or rule.

The Scholarship awards are not renewable, but students may reapply to the program each year so long as they meet the eligibility requirements.

Qualifications

Applicants of the scholarship must meet the following requirements:

- High school seniors or high school graduates who plan to enroll or are currently enrolled in a full-time undergraduate course of study to major in a health care field at an accredited two or four-year college, university or vocational-technical program;
- Cumulative grade point average of 3.0 or greater, calculated on a 4.0 grading scale;
- Students must have graduated from a high school within Sanford Canton-Inwood Medical Center's primary service area. Those qualifying schools include Canton High School (Canton, SD), West Lyon High School (Inwood, IA), Alcester-Hudson High School (Alcester, SD);
- Student is a graduate of a private school or home school and resides within Sanford Canton-Inwood Medical Center's primary service area;
- Parents of more than one qualifying student can submit multiple applications but only one scholarship will be awarded per family per year;
- Students may reapply every year they meet the eligible criteria.

Application

- Interested individuals must complete the official application form and mail it to Canton-Inwood Area Health Foundation, along with:
    - official, complete transcript of grades
    - official copy of composite ACT score (a high school transcript with this information is acceptable)
    - personal essay
    - three letters of reference
- Students who are not currently enrolled in an undergraduate program will also need to submit a copy of an acceptance letter from the college, university, or vocational-technical program.
- The application and references must be received by **March 24, 2023.**

Applicants are responsible for submitting all necessary information. Evaluation of applications is based on the information supplied and all questions must be answered completely. All information received is considered confidential and is reviewed only by the Canton-Inwood Area Health Foundation Scholarship Committee.

Selection

Canton-Inwood Area Health Foundation Health Care of Tomorrow Scholarship recipients will receive a $1,000.00 scholarship. Selection of recipients is made by the Canton-Inwood Area Health Foundation Scholarship Committee. All decisions are final. Applicants will receive written notification within the month of May 2023. Inquiries regarding the scholarship program should be submitted to: Canton-Inwood Area Health Foundation, Attn: Scholarship Committee, P.O. Box 292, Canton, SD 57013 – (605)764-1495. Due to the finite number of available scholarships, it is possible for a student to meet all criteria and not be selected. Students are encouraged to reapply each year they are eligible.

Canton-Inwood Area Health Care Foundation
2023 Health Care of Tomorrow Scholarship Application

The application and references must be submitted and received by **March 24, 2023.**
Please type or print legibly. If more space is needed, use additional paper and attach it to the application.

Application Information

Name _____
(Last) (First) (MI)

Permanent Address _____
(Street/PO Box) (City) (State) (Zip)

Telephone _____ E-Mail _____

Age _____ Date of Birth ____/____/____

Parent/Legal Guardian Information

Name _____
(Last) (First) (MI)

Address _____
(Street/PO Box) (City) (State) (Zip)

High School Information

High School Name _____

High School Address _____
(Street/PO Box) (City) (State) (Zip)

Telephone _____Graduation Date _____
(Month/Year)

Post-Secondary School Information

Name of accredited, undergraduate, post-secondary school you currently attend or plan to attend in the fall of 2023. (If unknown, please list in order of preference the schools to which you have been accepted.) Please do not abbreviate school names.

School Name_____

Complete Address _____
(Street/PO Box) (City) (State) (Zip)

School Name (2nd Preference) _____

Complete Address _____
(Street/PO Box) (City) (State) (Zip)

Year in post-secondary program next school year: ☐1 ☐ 2 ☐ 3 ☐4 ☐ 5

Major _____Anticipated Graduation Date _____

Academic Scholarships and Grants Awarded

(Use additional pages if necessary) (if does not apply use N/A)

1. Source_____ Amount of $_____
   Date Applied ____/____/____ Date Awarded ____/____/____

2. Source_____ Amount of $_____
   Date Applied ____/____/____ Date Awarded ____/____/____

3. Source_____ Amount of $_____
   Date Applied ____/____/____ Date Awarded ____/____/____

4. Source_____ Amount of $_____
   Date Applied ____/____/____ Date Awarded ____/____/____

5. Source_____ Amount of $_____
   Date Applied ____/____/____ Date Awarded ____/____/____

Essay

Topic: **Why do you want to pursue a career in health care?**

Essays will be rated on mechanics, style, grammar, and content. Please type the essay on a separate sheet of paper and include with application packet. Please limit to no more than 500 words.

Participation in School Activities

(Use additional pages if necessary) (if does not apply use N/A)

Group/Organization _____ Role: _____
Dates of Participation____/_____/_____ to _____/_____/_____

Group/Organization _____ Role: _____
Dates of Participation _____/_____/_____ to _____/_____/_____

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Group/Organization _____ Role: _____
Dates of Participation _____/_____/_____ to _____/_____/_____

Group/Organization _____ Role: _____
Dates of Participation _____/_____/_____ to _____/_____/_____

Participation in Community/Volunteer Activities

(Use additional pages if necessary) (if does not apply use N/A)

Group/Organization _____ Role: _____
Dates of Participation____/_____/_____ to _____/_____/_____

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Dates of Participation _____/_____/_____ to _____/_____/_____

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Dates of Participation _____/_____/_____ to _____/_____/_____

Letters of Recommendation

Three letters of recommendation are required. Please use the Scholarship Reference form provided. Reference letters may be included with your application or mailed to Canton-Inwood Area Health Foundation by the person completing the recommendation. All letters of recommendation must be received by **March 24, 2023.**

High School & Post-Secondary Transcript Information Required

Students must include an official transcript of grades for the last completed semester of study from their high school, college or vocational technical school. Applicant is responsible for ensuring the official transcript is submitted and received.

Please indicate below how your official transcript will be submitted to Canton-Inwood Area Health Foundation.
___ Enclosed is an official transcript from my last completed semester of study.
___ My official transcript will be sent to Canton-Inwood Area Health Foundation by my school.

Only official transcripts will be accepted. Copies or website print-out of grades will not be accepted as official transcripts.

My cumulative GPA is _____ for the last completed semester. (Based on a 4.0 grading scale.)

ACT Score

An official high school transcript that includes your ACT score is acceptable. If your transcript does not include your ACT score, please provide an official copy of your test results.

This application for a scholarship becomes complete and valid only when you have followed all the instructions below:

_____ Return completed and signed scholarship application.

_____ Return personal essay.

_____ Return official completed transcript of grades for the last semester completed.
Note: Some schools will only send transcripts directly to Canton-Inwood Area Health Foundation.

_____ Return an official copy of your ACT test results.
A high school transcript that includes your composite score is acceptable.

_____ Return 3 letters of reference.

_____ Students who are not currently enrolled in an undergraduate program will also need to submit a copy of an acceptance letter from a college, university, or vocational-technical program.

_____ Application and references must be received by **March 24, 2023.**

Application needs to be received by **March 24, 2023.** Send to:
Canton-Inwood Area Health Foundation
Attn: Scholarship Committee
P.O. Box 292
Canton, SD 57013

In submitting this application, I certify that the information provided is complete and accurate to the best of my knowledge. Any falsification of the required information and any missing information will disqualify me from receiving scholarship funds.

In the event I receive a scholarship, I grant permission to Canton-Inwood Area Health Foundation to use my name and photograph for promotional purposes, including, but not limited to, release to media.

Applicant's Signature _____ Date_____

Canton-Inwood
Area Health Foundation

2023 Canton-Inwood Area Health Foundation
Scholarship Reference

This form and personal letter of recommendation may be returned to the applicant in a sealed envelope or mailed to:

Canton Inwood Area Health Foundation
Attn: Scholarship Committee
P.O. Box 292
Canton, SD 57013

Reference must be received by Canton-Inwood Area Health Foundation by March 24, 2023.
Student's application will be considered incomplete if reference is not received by the deadline.

Applicant's name:

How long have you known this applicant?

In what capacity have you known this applicant?

Please attach a personal letter of recommendation that describes the attributes that qualify this applicant for a health care career. For example, scholastic ability, initiative, dependability, accountability, social skills, etc. Please include any unusual or remarkably distinctive qualities or attributes the applicant possesses that sets them apart from other applicants. Please limit to no more than 500 words.

Overall Evaluation: (Circle One) Highly Recommend Recommend Recommend with Reservations

Signature: _____ Date: _____

Printed Name: _____ Title: _____

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