CRITERIA FOR HEALTH CARE SCHOLARSHIP

I. GENERAL INFORMATION

A. Funding will be provided by the Auxiliary to South Texas Health System to qualified applicants who have applied for and been accepted into the following health care programs:

<table>
<thead>
<tr>
<th>Nursing</th>
<th>LVN, ADN, RN and BSN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy</td>
<td>Physical, Occupational, Speech and Respiratory</td>
</tr>
<tr>
<td>Technical</td>
<td>Medical, Laboratory and Radiology</td>
</tr>
<tr>
<td>Pre-Med</td>
<td>Doctor</td>
</tr>
<tr>
<td>Dietitian</td>
<td>Dietitian</td>
</tr>
<tr>
<td></td>
<td>Information Technology and Computer Science</td>
</tr>
</tbody>
</table>

B. Applicant must meet institution’s required program requisites.

C. If the application meets the indicated requirements, payment will be made directly to the applicant and the institution. Scholarships will be awarded in the amount of $2,000 annually, subject to the availability of funds. The money will be disbursed in $1,000 increments in August and January of each school year. Scholarship funds will only be awarded for courses that will be credited toward the degree.

II. REQUIREMENTS FOR APPLICATION

A. Proof of United Stated citizenship (birth certificate, passport, naturalization certificate or voter registration card).

B. Proof of current Residence in Hidalgo or Starr County. (Utility bill).

C. A completed application form.

D. A letter of acceptance from the health care program which the applicant plans to attend. Full time student must enroll in 12 or more hours. Part-time students (6-11 hours) will be reimbursed $700 per semester.

E. A final high school or recent university transcript verifying a 3.00 cumulative grade point average.

F. A paragraph of 200 words or less stating the applicant’s reason for choosing a specific health care program and the projected goals expected from a degree or licenser.

G. Three references or recommendations as designated: two from a previous school/faculty member or employer/supervisor, and one other reference (not family member).

H. A complete packet of documentation must be received by the Scholarship Committee on or before August 10th for all first-time applicants.
I. Funding is granted for only one year at a time for a maximum of 4 years.

J. A renewal form and complete transcript must be provided to the Auxiliary to South Texas Health System Scholarship Committee on or before June 10th of each year.

K. Disclosure of other financial aid or employer tuition assistance is required.

L. The completed application and listed requirements should be mailed to:

Auxiliary to South Texas Health System Scholarship Committee
P.O. Box 368
McAllen, TX 78505
AUXILIARY TO SOUTH TEXAS HEALTH SYSTEM
HEALTH CARE SCHOLARSHIP APPLICATION
Recent Photo

Scholarship deadlines to be observed for the consideration of your application:
Please Check One:
___ August 10th  – (Fall Semester) Original ___ June 10th - Renewal

Please print or type

Today’s Date: ____________________

Name ___________________________ Social Security # ___________________________

Last  First  Middle Initial

Address

Number/Street  City  County  State  Zip Code  Home Phone #

Place of Birth

Date of Birth
City/State/County

Month/Date/Year

Schools Attended:

High School ___________________________ Date of graduation ___________________________

College ___________________________ Degree ___________________________ Date ___________________________

What health care program have you been accepted: _____________________________________________

Anticipated date of graduation: ___________________________________________________________

If Applicable:

Father’s Name ___________________________ Occupation ___________________________

Address ___________________________ Phone ___________________________

Mother’s Name ___________________________ Occupation ___________________________

Address ___________________________ Phone ___________________________

Are you financially dependent on your parents/family member? Totally _________ Partially _________

Please list other sources of financial aid you have applied for or are receiving.

Source ___________________________ Amount ___________________________

Source ___________________________ Amount ___________________________

References (Not family member)
1. School/Faculty member/employee/supervisor

   Name ___________________________ Address ___________________________ Phone ___________________________

2. Name ___________________________ Address ___________________________ Phone ___________________________

Other Reference:
3. Name ___________________________ Address ___________________________ Phone ___________________________

***Attached are three Health Care Scholarship recommendation forms. Furnish each reference with legal sized stamped envelope. Please meet scholarship deadlines for scholarship consideration.
HEALTH CARE SCHOLARSHIP RECOMMENDATION

Student Name _____________________________ Social Security # _____________________________

The student named above has applied for a health care scholarship offered by the Auxiliary to South Texas Health System. Your candid evaluation of the student’s qualification is required. This recommendation form will be held in confidence. Please complete and mail immediately to:

Auxiliary to South Texas Health System Scholarship Committee
P.O. Box 368
McAllen, TX. 78505

RATING; 5 - Outstanding  3 - Average  1 - Poor
4 - Above Average  2 - Below Average  N/A - Unable to Rate

| Potential for Academic Success in College and Initiative to Excel | RATING |
| Ability to Work Alone and with Others | |
| Responsibility and Consistency in Work | |

Comment on additional reasons why you believe the student should receive a scholarship:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Print Name of Person Recommending: _____________________________ Date: ______________

Title/Occupation: _____________________________ Work Phone: ________ Home Phone: ________

Address: _____________________________________________________________

Relationship to Application: ____________________________________________

Signature: ____________________________
HEALTH CARE SCHOLARSHIP RECOMMENDATION

Student Name ___________________________________________ Social Security # ______________________

The student named above has applied for a health care scholarship offered by the Auxiliary to South Texas Health System. Your candid evaluation of the student’s qualification is required. This recommendation form will be held in confidence. Please complete and mail immediately to:

Auxiliary to South Texas Health System Scholarship Committee
P.O. Box 368
McAllen, TX. 78505

RATING; 5 - Outstanding  3 - Average  1 - Poor
4 - Above Average  2 - Below Average  N/A - Unable to Rate

<table>
<thead>
<tr>
<th>RATING</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential for Academic Success in College and Initiative to Excel</td>
<td></td>
</tr>
<tr>
<td>Ability to Work Alone and with Others</td>
<td></td>
</tr>
<tr>
<td>Responsibility and Consistency in Work</td>
<td></td>
</tr>
</tbody>
</table>

Comment on additional reasons why you believe the student should receive a scholarship:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Print Name of Person Recommending: ___________________________ Date: _____________

Title/Occupation: ___________________________ Work Phone: ___________________________ Home Phone: ___________________________

Address: ____________________________________________

Relationship to Application: ____________________________________________

________________________________________________________________________

Signature
HEALTH CARE SCHOLARSHIP RECOMMENDATION

Student Name ___________________________ Social Security # _______________________

The student named above has applied for a health care scholarship offered by the Auxiliary to South Texas Health System. Your candid evaluation of the student’s qualification is required. This recommendation form will be held in confidence. Please complete and mail immediately to:

Auxiliary to South Texas Health System Scholarship Committee
P.O. Box 368
McAllen, TX. 78505

RATING;  5 - Outstanding  3 - Average  1 - Poor
4 - Above Average  2 - Below Average  N/A - Unable to Rate

<table>
<thead>
<tr>
<th>RATING</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential for Academic Success in College and Initiative to Excel</td>
<td></td>
</tr>
<tr>
<td>Ability to Work Alone and with Others</td>
<td></td>
</tr>
<tr>
<td>Responsibility and Consistency in Work</td>
<td></td>
</tr>
</tbody>
</table>

Comment on additional reasons why you believe the student should receive a scholarship:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Print Name of Person Recommending: ___________________________ Date: __________

Title/Occupation: ___________________________ Work Phone: __________

Home Phone: __________

Address: ___________________________

Relationship to Application: ___________________________

________________________________________

Signature