



Application Received:
Information Comp:
Interview:
CC:
OFFICE USE ONLY

**Walter Scott Foundation
Scholarship Application**

Scholarship application, letter of recommendation, and essay must be submitted by May 31st of current year.

Name _____ Date _____ Employee # _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Department _____ Current Position _____ Hire Date _____

Job Status: (Circle One) FT PT

Accredited College or University attending: _____

Expected Graduation Date (MM/YY): _____ **(Please attach Letter of Acceptance)**

Nursing Degree pursuing:

_____ Associate's Degree _____ Bachelor's Degree

_____ Master's Degree _____ Doctorate

Previous Education Information

College Name: _____

City: _____ State: _____

Major: _____ GPA: _____ Degree: _____ Year: _____

Hours Completed: _____ Current Grade Point Average: _____

I would like to be on scholarship for _____ semesters/quarters beginning with the _____ semester/quarter.

(Fall, Winter, Etc. & Year) (circle one)

WORK EXPERIENCE

Employer:	Address:
Job Title:	Supervisor's Name/Title:
Dates of Employment: From: To:	Duties:
Employer:	Address:
Job Title:	Supervisor's Name/Title:
Dates of Employment: From: To:	Duties:
Employer:	Address:
Job Title:	Supervisor's Name/Title:
Dates of Employment: From: To:	Duties:

I believe I am deserving of a Walter Scott Foundation Scholarship because: (350 words or less – you may attach additional page if needed.)

Have you ever been discharged from a job or asked to resign? Yes _____ No _____

Have you ever been convicted of a crime (other than a minor traffic violation); pled guilty; no contest; been given deferred adjudication; or, been found guilty of a crime in a court of law? Yes _____ No _____

Are you a relative of anyone working for Southeast Health? Yes _____ No _____

If yes, please provide the following information about your relative:

Name: _____

Relationship: _____

Department: _____

_____ I have read and understand the requirements for the Walter Scott Foundation Scholarship.

_____ I certify that all information contained in this application is true, correct and falsification of information may result in denial and/or corrective action.

_____ I understand that my coursework must not interfere with my job responsibilities and/or job schedule.

_____ I understand there is a commitment to continue my part-time or full-time employment with Southeast Health for 1 year upon completion of coursework associated with this award.

_____ I understand that the Walter Scott Foundation Scholarship reserves the right to amend or terminate the offering of the Walter Scott Foundation Scholarship at any time.

_____ I understand that this is not a contract of employment, and that all employment with Southeast Health is voluntary and at-will, meaning that I or Southeast Health have the right to terminate the employment relationship at any time, for any reason or no reason, and that this agreement does not alter that at-will employment relationship.

Signed _____

Date _____

Return application to:

Southeast Health Foundation
Attn: Amy Bunting, Director
1806 Fairview Ave.
Dothan, AL 36301

Deadline for Application:

May 31st of current year

334.673.4150
sehealthfoundation@southeasthealth.org