Anderson Memorial Hospital Auxiliary-Medical Scholarship Criteria

Norway Area Community Foundation

Beginning in June of 1997, two scholarships will be awarded to Norway High School graduating seniors who meet the criteria described below. Funds for this scholarship were provided through a monetary donation of $40,000.00 from the Anderson Memorial Hospital Auxiliary. The interest earned annually on the principal shall be divided equally into two scholarships.

One scholarship will be issued to a student enrolling in a two- or four-year post-secondary program in the **medical field**. Should there not be an eligible recipient; a nursing scholarship will be awarded (see second scholarship below).

The second scholarship will be given to a student enrolled in a two- or four-year post-secondary program in a field of **nursing** in honor of Agnes Anderson.

1. The annual scholarships are for one year and may not be renewed.
2. The scholarship will be awarded after the recipient's first year of college/university is complete. Recipients shall be required to maintain a full-time student course load and a minimum GPA of 3.50. Recipients must provide the Dickinson Area Community Foundation with verification of their full-time status and required GPA in accordance with the Foundation's established policies for renewing scholarships.
3. Applicants must have a 2.70 or greater GPA in high school.
4. The recipients must have demonstrated the potential for success during high school and have committed to an advanced program of study.
5. Applications must be on file in the guidance office by **March 15th**. Failure to turn in your application by the due date will result in being ineligible to apply for this scholarship.
6. Financial need of the applicant shall be a major factor in the selection of students for the Scholarship, but not the sole factor, as outstanding academic achievement and strength of character shall also be considered factors in selection of recipients.
7. The selection committee will consist of the following:
   a. Two high school administrators
   b. Two high school teachers
   c. One or more representatives from the family of David Anderson, if available.
8. A scholarship award may be revoked by the DACF Board of Trustees because of:
   a. Criminal or anti-social conduct of recipient.
   b. Filing false information on application.
   c. For such other good cause as the Board may, in its sole discretion determine.

   Revocation shall be by the action of a majority of the members of the DACF Board of Trustees. Upon such revocation, any and all funds still controlled by the DACF Board of Trustees shall be withheld and disposed of at the discretion of the Board.

Anderson Memorial Hospital-Auxiliary Medical Scholarship

Norway Area Community Foundation

Completed applications must be submitted by March 15th

Date		
Full Name		
Street Address		
City ST ZIP Code		
Home & Cell Phone		
E-Mail (Required)		
High School Attended		
GPA		
Class Rank		**ACT Score:**
Leadership Experiences:		
Services to school:		
Services to community:		

Career goals after college:	
Did you work during the school year? No	**If yes, how many hours/week?**
Name of college or university you plan to attend:	
Have you applied for admission?	
Have you been accepted?	
Intended field of study:	
Have you applied for other scholarships?	
Have you been granted a scholarship? If so, name of scholarship & amount:	
Please include the following with the application:	
1. Copy of high school transcripts	
Application Deadline	
All applications need to be submitted to the guidance counselor's office **by March 15th.**	
Agreement and Signature	
By submitting this application, I affirm that the facts set forth in it are true and complete. I understand any false statements, omissions, or other misrepresentations made by me on this application may result in rejection of this application.	
Name (printed)	
Signature	
Date	
Parent Application Form	
Name of parent or guardian completing this form:	
Home address:	
Phone:	
Email:	

Do you have any dependents other than your own family or other extenuating circumstances that should be considered? If yes, please explain:
Note here any statements you may wish to make which assist the scholarship selection committee in consideration of the applicant:
Agreement & Signature:
I affirm that the statements above are true and complete. I understand any false statements, omissions, or other misrepresentations made by me on this application may result in rejection of this application.
Signature of parent or guardian:
Date:

RELEASE OF INFORMATION

I hereby certify that any information needed regarding my scholarship requirements be made available to the Director of the Dickinson Area Community Foundation and the Anderson Memorial Hospital-Auxiliary-Medical Scholarship Committee.

Signature of Applicant:_____ Date:_____