



## **Allen & Jennifer Disabled Combat Veterans Remembrance Medical Scholarship Criteria**

### **Norway Area Community Foundation an affiliate of the Dickinson Area Community Foundation**

*One or more scholarship recipient(s) will be chosen annually from Norway High School. The recipient(s) shall receive a four-year scholarship award in an amount to be determined annually based upon earned income of the fund.*

#### **Eligibility:**

1. Applicant must be a graduating Norway High School senior and be pursuing a degree in degree in a medical field.
2. Applicants must have a minimum GPA of 2.5 in high school and have demonstrated the ability to do college-level coursework.
3. Applicants must have been accepted at an accredited Michigan post-secondary institution.
4. Applicants must submit a brief statement/essay (200-250 words) stating why they chose their intended medical field and what their long-term goals are in this field.
5. A transcript of the student's high school records must be supplied.
6. Applicants must submit a reference letter from a teacher who has known the applicant for a minimum of one year. The reference letter must address the teacher's personal perception of the student's capabilities and skills to succeed in their chosen field of study. In addition, the reference letter should address the teacher's perception of the student's overall character.
7. The 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 major factors in student selection.
8. All applicants must adhere to the Guidance Counselor deadlines. Guidance counselors must forward applications to Dickinson Area Community Foundation by **March 15**. Failure to turn in a completed application by the due date will result in the student being ineligible to apply for this scholarship.
9. The scholarship is renewable for four years, with the award consisting of equal amounts distributed annually. To remain eligible for the renewable award, the recipient must be a full-time student (12 or more credit hours per semester or the equivalent), maintain a minimum GPA of 2.5, and continue to major in a medical field. The recipient must submit their official college transcript to the Dickinson Area Community Foundation (DACF) at the end of each spring semester (deadline June 30th) to confirm eligibility prior to award disbursement in accordance with DACF policy.

10. A scholarship award may be revoked by the DACF Board of Trustees because of:

- Criminal or anti-social conduct of recipient.
- Filing false information on application.
- Scholastic inadequacy of a recipient.
- Failure to provide DACF with documents and verification as specified in the Foundation's established policies for renewing scholarships.
- 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, and upon such revocation, any and all funds still controlled by the Board of Trustees shall be withheld and disposed of at the discretion of the Board.



# *Allen & Jennifer Disabled Combat Veterans Remembrance Medical Scholarship*

**Norway Area Community Foundation**  
 an affiliate of the Dickinson Area Community Foundation  
 Completed applications must be submitted by March 15th

<b>Date</b>	
<b>First / Last Name</b>	
<b>Street Address</b>	
<b>City ST ZIP Code</b>	
<b>Home &amp; Cell Phone</b>	
<b>E-Mail Address</b>	
<b>High School Attended</b>	
<b>GPA</b>	
<b>Name of school you plan to attend:</b>	
<b>Have you applied for admission?</b>	
<b>Have you been accepted?</b>	
<b>Intended field of study:</b>	
<b>Did you work during the school year?</b>	
<b>Weekly earnings:</b>	
<b>Approximate amount of savings:</b>	
<b>Name of person(s) dependent upon your earnings (if any)?</b>	
<b>Will you work while attending college?</b>	
<b>If so, for what portion of your expenses?</b>	

<b>How much do you estimate it will cost you to go to the college of your choice for one year?</b>	
<b>Tuition &amp; Fees</b>	\$ _____
<b>Room &amp; Board</b>	\$ _____
<b>Books &amp; Supplies</b>	\$ _____
<b>Miscellaneous</b>	\$ _____
<b>Total:</b>	\$ _____
<b>Will you attend college if you do not receive a scholarship?</b>	
<b>Please include the following with the application:</b>	
<ol style="list-style-type: none"> <li>1. Applicants must submit a reference letter from a teacher who has known the applicant for a minimum of one year. The reference letter must address the teacher's personal perception of the student's capabilities and skills to succeed in their chosen field of study. In addition, the reference letter should address the teacher's perception of the student's overall character.</li> <li>2. Applicants must submit a brief statement/essay (200-250 words) stating why they chose their intended medical field and what their long-term goals are in this field.</li> <li>3. Applicants must submit a copy of their high school transcript.</li> </ol>	
<b>Application Deadline</b>	
All applicants must adhere to the Guidance Counselor deadlines. Guidance counselors must forward applications to Dickinson Area Community Foundation by <b>March 15</b> .	
<b>Applicant Agreement and Signature</b>	
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	
<b>Parent/Guardian Application Form</b>	
Name of parent or guardian completing this form:	
Home address:	
Phone:	
<b>What was the family income for the year 20__? \$ _____</b>	
<b>What was the source of the income?</b>	

<b>What was the general distribution of your income for 20__?</b>
<b>Do you have any other dependents or extenuating circumstances that should be considered? If yes, please explain:</b>
<b>Please note here any additional information which may assist the scholarship selection committee in consideration of the applicant:</b>
<b>Parent/Guardian Agreement &amp; Signature:</b>
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 Allen & Jennifer Disabled Combat Veterans Remembrance Medical Scholarship Committee.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_