

## **Huron Family Memorial Scholarship Fund Criteria Dickinson Area Community Foundation**

*One (1) Scholarship recipient will be chosen annually. The recipient shall receive a one-time Scholarship Award in an amount to be determined annually based upon earned income of the fund.*

### **Eligibility:**

1. The applicant must be an employee of Marshfield Medical Center-Dickinson for one year or more.
2. The person must be enrolled in or enrolling in a medical curriculum to be eligible.
3. Each application form must be signed by the employee and their department manager.
4. The recipient must start using the scholarship in the summer or fall of the year receiving the award or it will be given to the alternate.
5. Applicant must submit a one-page, double-spaced 12 point font essay explaining why you chose your particular medical profession.
6. Applicant must have three (3) letters of recommendation from non-family members.
7. Applications with references must be received in the Dickinson Area Community Foundation office by **April 17<sup>th</sup>**.
8. All applications must be accompanied by a copy of a letter of acceptance or registration from the school you will be attending.
9. Completed applications packages must be sent to the DACF office by **April 17<sup>th</sup>**:  
Dickinson Area Community Foundation  
220 E Hughitt Street  
Iron Mountain, MI 49801

### **Addendum:**

A scholarship award may be revoked by the DACF Board of Trustee because of:

- Criminal or anti-social conduct of recipient.
- Filing false information on application.
- Scholastic inadequacy of a recipient.
- Failure to provide the Dickinson Area Community Foundation 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.

## *Huron Family Memorial Scholarship*

**Dickinson Area Community Foundation**

**Completed applications must be submitted by April 17**

<b>Date</b>	
<b>Name</b>	
<b>Street Address</b>	
<b>City ST ZIP Code</b>	
<b>Home &amp; Cell Phone</b>	
<b>Email Address</b>	
<b>High School Graduated from:</b>	
<b>Year of Graduation</b>	
<b>Scholastic Average</b>	
<b>College Attending or Attended:</b>	
<b>Other Educational Training:</b>	
<b>Work Experience:</b>	

<b>Name of school or college you plan on attending:</b>	
<b>Are you presently accepted/enrolled?</b>	
<b>Please include the following with the application:</b>	
<ol style="list-style-type: none"> <li>1. Three (3) letters of recommendation from a non-family member such as an employer, clergy, doctor, etc.</li> <li>2. Write a short essay (one page, double-spaced 12 pt. font) on why you chose your particular medical profession.</li> <li>3. Copy of a letter or registration from the school you will be attending.</li> </ol>	
<b>Application Deadline</b>	
<p>All applications need to be submitted to the DACF office or mailed to the following address <b>by April 17<sup>th</sup></b>.</p> <p>Dickinson Area Community Foundation 220 E Hughitt Street Iron Mountain, MI 49801</p>	
<b>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	
Department Manager Signature	
Date	
Email Address	

### 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 Huron Family Memorial Advisory Board.

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