

# Maxine and Dwane Morehead Nursing Scholarship Fund

## Guidelines

**PURPOSE:** Shall be available to persons pursuing an **undergraduate degree in nursing**.

2. Shall be available foremost for persons needing financial aid.
3. Shall be available to anyone in the Jackson County Regional Health Center service area. Said service area to be determined at the discretion of Scholarship Committee.
4. The number of scholarships awarded shall be determined by funds available at the time the scholarships are awarded. The amounts of individual scholarships may vary from \$200 to \$2,000. This provision, and amounts, shall be reevaluated periodically.
5. Monies awarded by this scholarship shall be used for tuition, books, room and board.
6. Monies awarded shall be paid to college and student jointly.
7. A new application is necessary each year funds are applied for with current references.
8. Having received or denied a scholarship one year shall not deter a person from applying in subsequent years.
9. Application forms shall be available by February 1 each year from Jackson County Regional Health Center (JCRHC), JCRHC website, school counselors, or Morehead Scholarship Committee Members.
10. Application forms must be completed and returned by April 1, (postmarked by March 31) to the office of the Jackson County Regional Health Center Administration Office.
11. Announcements of scholarship awards shall be made by May 15.
12. Preference shall be given to full time students (12 hours minimum). This point left to the discretion of the Scholarship Committee.
13. The Maxine and Dwane Morehead Scholarship Committee shall consist of 5 members, whose duties shall be to evaluate scholarship applications, select recipients, and determine money awards. All decisions shall be reviewed at the prerogative of the Jackson County Health Foundation Board.
14. The 5 member Scholarship Committee shall consist of:
  - 1) Representative from the Jackson County Regional Health Center Auxiliary;
  - 2) Education Director of Jackson County Regional Health Center;
  - 3) 4) and 5) at large, from Jackson County Regional Health Center service area, who shall serve terms of 1, 2, and 3 years, (term being 3 years).



# MAXINE AND DWANE MOREHEAD NURSING SCHOLARSHIP FUND

Administered by the Jackson County Hospital Foundation

## APPLICANT INFORMATION

Applicant Name \_\_\_\_\_ Birth date \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_  
E-mail Address \_\_\_\_\_  
(please list personal email, not school as that is often blocked)  
Marital Status ☐ single ☐ married ☐ divorced ☐ widow  
Spouse's Name \_\_\_\_\_ Number of dependent children \_\_\_\_\_

### **Complete this section if dependent of parents**

Father's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_ Yearly salary: \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_ Yearly salary: \_\_\_\_\_  
Number of children in the family: \_\_\_\_\_ Number of dependent children: \_\_\_\_\_  
Ages of dependent children: \_\_\_\_\_  
Number of siblings now in college: \_\_\_\_\_

## EDUCATION INFORMATION

High School Attended \_\_\_\_\_  
Date of Graduation \_\_\_\_\_ Grade Point \_\_\_\_\_  
ACT score \_\_\_\_\_ SAT score \_\_\_\_\_ Date taken \_\_\_\_\_

### ***\*\*A transcript of grades must accompany this application\*\****

*High school graduates (first year applicants) must supply a high school transcript. College students must provide a college transcript.*

College you plan to attend or are enrolled in \_\_\_\_\_  
Location \_\_\_\_\_ Have you been accepted? ☐ Yes ☐ No  
Course you plan to pursue in college \_\_\_\_\_ ☐ Full Time (>12 hrs.) ☐ Part Time (<12 hrs.)  
Years Required \_\_\_\_\_ Approximate date of completion \_\_\_\_\_ Number of credit hours \_\_\_\_\_

### Approximate cost of school year:

Tuition \$ \_\_\_\_\_  
Books \$ \_\_\_\_\_  
Room & Board \$ \_\_\_\_\_

### Sources of income and approximate amounts available to you:

Parents/Spouse \$ \_\_\_\_\_  
Savings \$ \_\_\_\_\_  
Scholarships/Grants \$ \_\_\_\_\_

Are you presently employed? ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time Yearly Salary \$ \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Will you work during the school year? ☐ Yes ☐ No  
Spouse's Occupation & Employer \_\_\_\_\_ Yearly Salary \$ \_\_\_\_\_

## FINANCIAL INFORMATION

**NOTICE: This page is separate for confidentiality and is only to assist the committee in making their decision. We respect your personal statements which will be kept only within the committee and destroyed after a decision is made.**

Parent's (or spouse as applicable) combined income for year \$ \_\_\_\_\_

Parent's Federal Income Tax paid last year (if dependent of parents) \$ \_\_\_\_\_

Federal Income Tax paid last year for self (include spouse if applicable) \$ \_\_\_\_\_

Value of property owned- Parents \$ \_\_\_\_\_ Self \$ \_\_\_\_\_

Debt on property owned- Parents \$ \_\_\_\_\_ Self \$ \_\_\_\_\_

Other siblings (dependents) enrolled in college: ☐ Yes ☐ No

# in year: Freshman \_\_\_\_\_ Sophomore \_\_\_\_\_ Junior \_\_\_\_\_ Senior \_\_\_\_\_

Are you receiving monies from a trust fund? ☐ Yes ☐ No Amount \$ \_\_\_\_\_

***The above is an accurate statement of my financial information.***

## PERSONAL LETTER

*The personal letter should highlight your honors, achievements, extracurricular activities, outside interests, and goals, reflecting on your current stage in life, the past year's experiences, and aspirations for the future.*

## STATEMENT OF INTENT

*If awarded a scholarship from the Jackson County Hospital Foundation on behalf of the Morehead Scholarship, I understand that I will be expected to forfeit the scholarship if I do not continue my schooling for any reason or change my major and am no longer studying nursing. Such changes must immediately be reported to the committee for review. I also understand that any money not used for schooling will be returned to the Jackson County Hospital Foundation.*

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

### CHECKLIST FOR COMPLETED APPLICATION

- \_\_\_\_\_ Completed application
- \_\_\_\_\_ Personal letter from applicant
- \_\_\_\_\_ Three (3) **current, dated** letters of recommendation (1 from principal/counselor or dean/advisor. If in college, should be from college representative.)
- \_\_\_\_\_ Current transcript of grades
- \_\_\_\_\_ All applicable questions and sections completed

**Please review the checklist carefully. If all information is not received, your application will be disqualified.**  
***Late packets and/or packets with postage due will be disqualified.***

Place all forms together in one packet and either mail, with sufficient postage, postmarked by March 31, to:

Jackson County Regional Health Center  
Attn: Administration Office  
Morehead Scholarship Committee  
601 Hospital Drive  
Maquoketa, Iowa 52060-0910

**OR**

Packet may be turned in to Jackson County Regional Health Center Administration Office personally.  
**Must** be returned by **April 1**. to be considered.

Morehead Scholarship Committee:  
Ashley James, Jackie Crowley, Carol Atkinson, Josie DeVries, Janet Treat