



# ADIRONDACK MEDICAL CENTER FOUNDATION

## SCHOLARSHIP APPLICATION

### HEALTH CARE SCHOLARSHIP PROGRAM

*The Adirondack Medical Center Foundation's (the "Foundation") mission is to support Adirondack Medical Center's efforts in promoting health care in the community. As part of this mission, the Foundation has created a Health Care Scholarship Program that awards three scholarships per year for the payment of tuition for certain area nursing and allied health care educational and training programs. The intent of this Scholarship Program is help to provide an educated and trained health care workforce in the area at a time when there is a growing shortage of health care workers.*

### HOW TO APPLY

***This application must be submitted no later than April 15<sup>th</sup> with the information requested below.***

***The application will not be reviewed unless all of the required information has been received.***

***Please answer each question as it is presented on the application.***

***If a question does not apply to you, mark your answer with n/a.***

All applicants must submit the following:

1. A completed and signed Scholarship Application and Scholarship Agreement (see attached).
2. A copy of a letter of acceptance from an approved accredited program indicating you have been accepted into a program leading to a degree in nursing or allied health care.
3. A transcript of your high school grades showing all grades, including SAT & ACT scores, regents grades, your class rank and cumulative average.
4. On a separate sheet of paper, write a personal statement of no more than one page detailing your career aspirations, personal goals, leadership roles, activities or honors in high school and the community, your financial need and other comments relevant to your application.
5. Please submit a letter of recommendation from a non-relative faculty member (for high school students) or a non-relative supervisor (for non-traditional students). The letter of recommendation must be submitted with your application.
6. Page 1 & 2 of your most recent tax return (IRS Form 1040). If you are a dependent of your parents, you must submit page 1 and 2 of their most recent tax return (IRS Form 1040).

**Submit this application to:**  
Scholarship Committee  
Adirondack Medical Center Foundation  
P.O. Box 120  
Saranac Lake, NY 12983

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### ELIGIBILITY

- The AMC Foundation Scholarship Committee determines each award individually based on the required information that is provided by the applicant during the application process.
- Applicants must provide proof that they have been accepted into a course of study leading to a degree in nursing or an approved allied health care career.
- Applicants must be full time students taking a minimum of 12 credit hours per semester.
- Applicants must live within the primary service area of Adirondack Medical Center and/or have graduated from one of the following high schools: Lake Placid, Saranac Lake, Tupper Lake, AuSable Valley, Keene Central, Long Lake or St. Regis Falls.
- Recipients must be in good standing and maintain a grade point average of 3.0 or higher while enrolled in order to be considered for a second year scholarship and not be subject to repayment of scholarship amounts previously awarded.
- At the time of application, applicants must agree in writing to work for Adirondack Medical Center for one (1) year after graduation, if a position is available (as determined by Adirondack Medical Center).
- At the time of application, Applicants must agree in writing to repay any scholarship amounts awarded if the applicant fails to meet the requirements of the program.

**PERSONAL PROFILE**

Please Print or Type:

Name \_\_\_\_\_  
(First) (M.I.) (Last)

Home Address: \_\_\_\_\_  
(Street Address including number)

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ Email address: \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_

Do you reside with your parents or spouse? Yes \_\_\_\_\_ No \_\_\_\_\_ (please circle which one)

Name of Parents/Spouse \_\_\_\_\_

Occupation of Parents/Spouse \_\_\_\_\_

List Other Family Dependents Along with Ages \_\_\_\_\_

Total adjusted gross income for the last calendar year according to IRS form 1040:

Parents' / Household's Gross Income: \_\_\_\_\_ Year: \_\_\_\_\_

Did you have income in the previous year? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, how much employment income did you earn? \$ \_\_\_\_\_ Where were you employed? \_\_\_\_\_

Present employment: \_\_\_\_\_ Full time \_\_\_\_\_ Part time \_\_\_\_\_

Do you have an immediate family member\* who is currently, or has ever been, employed by Adirondack Medical Center or the Adirondack Medical Center Foundation? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide the person's name, title and relationship to you: \_\_\_\_\_

\_\_\_\_\_

*\* "Immediate family member" means your (1) husband or wife, (2) birth or adoptive parent, child or sibling, (3) stepparent, stepchild, stepbrother or stepsister, (4) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law, (5) grandparent or grandchild, or (6) spouse of a grandparent or grandchild.*

Do you have an immediate family member\* who is currently, or ever was, on the medical staff of Adirondack Medical Center? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please the person's name and relationship to you: \_\_\_\_\_

\_\_\_\_\_

*\* "Immediate family member" means your (1) husband or wife, (2) birth or adoptive parent, child or sibling, (3) stepparent, stepchild, stepbrother or stepsister, (4) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law, (5) grandparent or grandchild, or (6) spouse of a grandparent or grandchild.*

What accredited college will you be attending? \_\_\_\_\_

What course of study do you intend to follow? \_\_\_\_\_

Are you a U.S. Citizen? \_\_\_\_\_ If no, please explain: \_\_\_\_\_

Have you ever been convicted of committing a felony offense involving marijuana, controlled substances or dangerous drugs or an assault, physical injury or death? No \_\_\_ Yes \_\_\_  
If yes, please explain: \_\_\_\_\_

Are you in default or do you owe a refund on any educational loan? No \_\_\_ Yes \_\_\_  
If yes, please explain: \_\_\_\_\_

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**RECOMMENDATIONS**

Please submit a letter of recommendation from a non-relative – **for high school students**, a faculty member; **for non-traditional students**, your immediate supervisor.

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**ACADEMIC PROFILE**

Name of High School Attended: \_\_\_\_\_

Address: \_\_\_\_\_

**For High School Students:**

Expected Date of Graduation: \_\_\_\_\_ Please attach a copy of your high school transcript showing SAT & ACT scores, regents grades, your class rank and cumulative average.

**For Non-Traditional Students:**

Year of High School Graduation: \_\_\_\_\_

Other institutions previously attended and hours earned (if any):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Entrance: \_\_\_\_\_

In what educational program were you enrolled?

Associates \_\_\_ Bachelors \_\_\_ Masters \_\_\_ In what major? \_\_\_\_\_

Please attach a transcript of your grades.

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FINANCIAL INFORMATION

**Please note: Each line of the financial information section of the application must be completed.  
If you are not receiving aid or income in the categories listed below,  
please mark that line with "n/a" as not applicable.**

**Academic Program Costs and Support**

What is the estimated annual cost at the college you expect to attend?

Tuition:	\$ _____	Books:	\$ _____
Room:	\$ _____	Incidentals:	\$ _____
Board:	\$ _____	<b>TOTAL COSTS:</b>	<b>\$ _____</b>

Please indicate the level of support you will be or are currently receiving from the programs listed below on an annual basis. Indicate the amount for each (estimate aid if you don't have exact figures).

Pell Grant	\$ _____	Voc Rehab	\$ _____
Scholarship	\$ _____	V.A. Benefits	\$ _____
Work Study	\$ _____	Other	\$ _____
Student Loans	\$ _____	<b>TOTAL SUPPORT:</b>	<b>\$ _____</b>

**Income**

Please indicate the annual income you anticipate upon college entrance from the sources listed below. Indicate the amount for each.

Parental Support	\$ _____	Unemployment	\$ _____
Employment	\$ _____	Social Security	\$ _____
Child Support	\$ _____	Worker's Comp	\$ _____
Alimony	\$ _____	Other	\$ _____
Social Services	\$ _____	<b>TOTAL INCOME:</b>	<b>\$ _____</b>

**Verify your adjusted gross income:**

**You must include a copy of Page 1 & 2 of your recent tax return - IRS Form 1040.  
If you are a dependent of your parents,  
you must include page 1 & 2 of your parents most recent IRS 1040.**

## AGREEMENT

I certify that the information I have provided in this application is true and accurate. I will notify the Foundation if any of this information changes.

I understand and agree that the purpose of the Scholarship Program is to defray the cost of tuition and any scholarship awards will be made payable each semester to the school that I am attending, so long as I have met all of the Scholarship Program requirements.

I understand and agree that I am obligated to repay the full amount of any scholarship awarded, if I change my course of study to something other than a nursing or allied health care field, as the case may be, or fail to meet the requirements of the Scholarship Program, as described in the Health Care Scholarship Program Agreement.

I understand and agree that the scholarships offered by the Adirondack Medical Center Foundation are dependent upon the availability of Foundation funding and cannot be guaranteed.

I understand and agree that I am obligated to notify the Foundation if my student status changes from that which is indicated in this application.

I hereby give permission to use any general, non-financial information included with this application for publicity purposes; to provide the Foundation with photographs of myself and give permission for the usage of such photographs; and to participate in scholarship recognition ceremonies of the Foundation's choosing.

I hereby authorize the release of this application and any relevant supporting information to person involved in the selection process and awarding of scholarship recipients.

**Applicant's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## ADIRONDACK MEDICAL CENTER FOUNDATION

### HEALTH CARE SCHOLARSHIP PROGRAM AGREEMENT AND PROMISSORY NOTE

I, \_\_\_\_\_, by applying for the Health Care Scholarship Program offered by the Adirondack Medical Center Foundation, do hereby agree as follows.

#### Scholarship Recipient Responsibilities

If I am awarded a Health Care Scholarship, I agree that I shall:

- Maintain satisfactory progress in a course of study leading to a degree in nursing or an allied health care field of study. Satisfactory progress means being in good standing and maintaining a grade point average of 3.0 or higher for each quarter or semester of the two-year program.
- Submit a grade report for each quarter or semester along with a course schedule for the upcoming semester or quarter immediately after the completion of each semester or quarter. I understand that further scholarship funds may not be awarded if I have not maintained satisfactory progress in my course of study.
- Keep the Adirondack Medical Center Foundation apprised of any change in my academic status while receiving scholarship assistance.
- During my final semester, verify with the Foundation that I have consulted with the Adirondack Medical Center Human Resources Office regarding possibilities for employment. *Such consultation in no way assures employment with Adirondack Medical Center.*
- Upon sixty (60) days of graduation, work at Adirondack Medical Center for a period of one (1) year in a position that requires the degree awarded during my course of study, assuming a position is available as determined by Adirondack Medical Center in its sole discretion.

#### Repayment Requirements

1. I understand and agree that I shall be required to repay any scholarship amounts awarded if the following occurs:

- I fail to maintain satisfactory progress, as defined above, in a course of study leading to a degree in nursing or an allied health care field of study for each quarter or semester that I am enrolled in the program.
- I fail to complete the program within two (2) years.
- I fail to accept employment at Adirondack Medical Center if a position is available within sixty (60) days of graduation.
- If such employment is offered and accepted, I fail to continuously work for Adirondack Medical Center for a period of one (1) year.
- I fail to meet any other requirements of the program.

2. If any of the events specified in Repayment Requirements, Section 1 occur, I hereby promise and agree to pay to the order of the Adirondack Medical Center Foundation the total amount of scholarship funds awarded, with interest compounded at the current Wall Street Journal prime rate as published in the *Wall Street Journal*, in regular monthly payments within a period not to exceed twenty-four (24) months.

3. Adirondack Medical Center reserves the right to waive the interest payment if extenuating circumstances exist.

4. I understand that that I may prepay this note wholly or in part at any time without penalty.

5. In the event that I return to employment at Adirondack Medical Center within twelve (12) months of graduation and fulfill the remainder of the work time required under the terms of the program, the Adirondack Medical Center Foundation may decide, in its sole discretion, to forgive the remaining principal and interest due and payable.

6. If employment is not available at Adirondack Medical Center within my field of study within sixty (60) days of graduation, I understand that I am not obligated to repay any scholarship funds awarded.

### **Default and Acceleration**

1. I understand and agree that if I default on the payment of the principal and interest, the entire unpaid balance of this note shall become immediately due and payable with attorney fees and costs of collection.

2. I understand and agree that in lieu of accelerating this note, Adirondack Medical Center Foundation may at its option impose a fine of ten percent (10%) of the amount of any delinquent installment hereunder.

### **Miscellaneous**

1. I understand and agree that the scholarships offered by the Adirondack Medical Center Foundation are dependent upon the availability of Foundation funding and cannot be guaranteed.

2. I understand and agree that such scholarships may be considered taxable by the Internal Revenue Service and that I am responsible for any tax liability incurred as a result of this award. The Adirondack Medical Center Foundation will provide no tax information to me or to the Internal Revenue Service.

I hereby consent and agree to the foregoing.

**Student Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

-----**For Office Use Only**-----

Application received completed with all attachments.

Date: \_\_\_\_\_

Date application approved: \_\_\_\_\_

Award amount \$ \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

AMC Foundation Executive Director

/CBR  
10/07  
C:\Scholarship\Application