



**OSF HEALTHCARE**  
Foundation

## **OSF HEALTHCARE FOUNDATION EDUCATIONAL LOAN ASSISTANCE PROGRAM FOR HEALTH CARE CAREERS APPLICATION**

### **General Information**

This educational assistance program is open to outstanding individuals pursuing advanced degrees in patient care health related fields. The program is open to individuals accepted to a program in the medical field; including current Mission Partners of OSF HealthCare in the I-80 Service Area, graduating high school seniors planning to attend a college of higher education or current college students enrolled in an accredited college or university, whose primary residence is in a community served by OSF HealthCare in the I-80 Service Area.

The amount awarded may be up to \$5,000 per level of education/program and must be applied toward tuition and fees and will be paid directly to the college or university. This may be a one- time award or split over the years of a program. *Example: \$5000.00 may be awarded over a 2 year period to assist in reaching RN, the applicant may then apply for additional dollars as they work toward BSN.*

Please mail completed application and requested documentation to:

**OSF HealthCare Saint Elizabeth Medical Center  
Attn: Education Loan Program Committee / HR  
1100 E. Norris Drive  
Ottawa, IL 61350**

**NOTE:** Application & Documentation **MUST BE** postmarked by **June 15, 2022** to be considered.

Please contact the OSF HealthCare Saint Elizabeth Human Resources department at (815) 431-5318 or email [amy.l.gross@osfhealthcare.org](mailto:amy.l.gross@osfhealthcare.org) if you have any questions.

**PLEASE READ THE FOLLOWING CAREFULLY**

**Student Eligibility**

The applicant must complete and submit the following application to the OSF HealthCare Saint Elizabeth Human Resources office.

The application must include:

- a) **Letter of acceptance into program the degree you are seeking to obtain.** (if not currently enrolled) from the educational institution you will attend.
- b) Current high school/college transcript
- c) A written release permitting the selection committee to review the student's academic, clinical and extracurricular records (release form included in packet).
- d) A summary of significant academic and curricular achievements at the college or in the community with a listing of references.
- e) A brief statement of educational goals, as outlined in the application.

Awarding or denying financial assistance will be based, among other things, upon ACT, SAT or an equivalent college entrance exam, high school record, social and community activities, volunteerism, previous high school/college records, personal references and one page essay. Include work history of present employer, if applicable.

The OSF HealthCare Foundation Loan Program Committee will determine the number of students who will receive financial assistance and the amount each will receive based on the following criteria:

- f) **Completion & submission of items a-e above.**
- g) **Educational Achievement:** Attach an official copy of your most current transcript from your latest academic year. A minimum cumulative G.P.A. of 3.0 out of 4.0 or 4.0 out of 5.0 is required.
- h) **Financial Need:** Include information on the application pertaining to other sources of educational assistance. If applicable, please include FAFSA results with the application.
- i) **Essay Content:** Include a short essay (one typed page only/350 words) as requested in the application.
- j) **Letters of Recommendation:**
  - Two (2) favorable academic letters of recommendation (forms included) attesting to your academic achievement, goals and character,
  - Two (2) favorable letters of recommendation from employers or a non-family member attesting to your achievements, character and goals

**\*All four (4) letters are to be signed, dated and handled as instructed on page #7 of application.**

- k) **Student agrees to work or continue to work at OSF HealthCare Saint Elizabeth Medical Center or within the I-80 OSF Service Area following degree completion for the required time frame in a patient care health field.**

Key factors in determining awards will be an interview with the OSF HealthCare Foundation Loan Program Committee and the review of application and required supporting documents as outlined in this application. All decisions are final.

**OBLIGATIONS - WHAT THE APPLICANT AGREES TO:**

The applicant hereby agrees to employment with OSF HealthCare Saint Elizabeth Medical Center or within the I-80 OSF Service Area for a minimum commitment period of one (1) year. If working full-time, the applicant would be committed to work 2,080 hours for awards received up to \$2,500. If financial assistance exceeds \$2,500, a commitment period would continue until the applicant has worked 2,080 hours for each \$2,500 awarded. Thus, for a \$5,000 award, the employee would be required to work 4,160 hours. This obligation is in effect after receiving an offer of employment from OSF HealthCare. The commitment period will commence 90 days after the individual's start date with OSF HealthCare if not employed prior to degree completion. If the individual is a new graduate or has not received their registry or certification, the commitment begins when it is received.

If a student fails to complete the educational program covered under this Agreement, the student must notify the Human Resources Department within seven (7) calendar days of such failure and repay the entire amount paid by the OSF HealthCare Foundation immediately, as outlined in agreement. The applicant agrees to pay legal and other costs incurred by the OSF HealthCare Foundation in enforcing this Agreement.

The student must submit his/her grades at the end of each semester to the Human Resources Department for committee review. If a recipient changes from full-time to part-time student status, he/she is to contact Human Resources as soon as possible. If a student drops or fails a course during the period of the educational assistance, or fails to maintain the required cumulative G.P.A., the student will not receive any additional funding beyond that specified in the Agreement, and at the sole discretion of OSF HealthCare Foundation Loan Selection Committee, the student may be required to satisfy the obligations set forth in Paragraph 1 under "Obligations-What The Applicant Agrees to" within 60 days of the subsequent graduation date or repay the amount awarded within 30 days.

**OSF HEALTHCARE FOUNDATION EDUCATIONAL LOAN ASSISTANCE PROGRAM  
FOR HEALTH CAREERS APPLICATION**

1. Full Name: \_\_\_\_\_

2. Present Address: \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_ Cell # \_\_\_\_\_

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

3. Permanent Address & Phone #( same as above): \_\_\_\_\_

\_\_\_\_\_

4. What is your professional occupational goal: \_\_\_\_\_

\_\_\_\_\_

5. What school will you attend this fall: \_\_\_\_\_

\_\_\_\_\_

6. Number of credit hours attending this fall: \_\_\_\_\_ 7. Expected Graduation Date: \_\_\_\_\_

8. If part-time, specify what else you will be doing: \_\_\_\_\_

\_\_\_\_\_

9. Residence Plans: *Dormitory* \_\_\_\_\_ *Home* \_\_\_\_\_ *Other (Specify)* \_\_\_\_\_

10. What is your course of study/declared major: \_\_\_\_\_

11. What is your expected academic level as of September: \_\_\_\_\_

12. What is your cumulative grade point average: \_\_\_\_\_

13. Have you taken post-high school study in a field other than that which you will be in this fall? If so, what course(s) and how do you explain your change of interest:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14. Have you applied for or will you be receiving other financial awards/scholarships/grants for the next year, including OSF educational assistance? If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

15. What particular qualifications do you feel you have for the occupation you have chosen? When did you decide on this field, and what were some of the factors which led to your decision:

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16. Discuss how OSF HealthCare has benefited your family or you:

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22. Please explain how you see yourself contributing to the future of healthcare in your local community:

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23. **Personal Essay.** Please provide a carefully constructed statement about why you are interested in pursuing a career in the healthcare field and your aspiration and goals within the healthcare field. Include any information about yourself that you would like the selection committee to consider in evaluating your application.

**Please type your essay on 8½” x 11” paper and attach to this application.**

**Be certain to identify it with your name and Item #23.**

24. What honors, academic or otherwise, have you received and when: \_\_\_\_\_

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25. In what health or science-related fields or activities have you been involved, either for recreation, as a volunteer or an employee: \_\_\_\_\_

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26. Below, list your resources and your anticipated expenses for the coming school year.

| <b>RESOURCES (estimated per academic year)</b> |          | <b>EXPENSES (estimated per academic year)</b> |          |
|--|----------|---|----------|
| Parents  | \$ _____ | Tuition & Fees                                | \$ _____ |
| Friends/Relatives                              | \$ _____ | Room  | \$ _____ |
| Personal Savings                               | \$ _____ | Board   | \$ _____ |
| Employment                                     | \$ _____ | Books & Supplies                              | \$ _____ |
| Loans  | \$ _____ | Transportation                                | \$ _____ |
| Other*   | \$ _____ | Personal & Other                              | \$ _____ |
| <b>TOTAL</b>                                   | \$ _____ | <b>TOTAL</b>                                  | \$ _____ |

27. List other financial awards, scholarships, grants, FAFSA, etc. that you have received or applied for:

| SCHOLARSHIP, GRANT, ETC. | DATE/AMOUNT RECEIVED | DATE/AMOUNT APPLIED FOR |
|--------------------------|----------------------|-------------------------|
| _____                    | _____                | _____                   |
| _____                    | _____                | _____                   |
| _____                    | _____                | _____                   |

28. **Letters of Recommendation:** List the names and addresses of the four (4) persons who are writing your letters of recommendation. **Two (2)** must be academic letters of recommendation (forms included) attesting to your academic achievement, goals and character. **Two (2)** must be a non-family character reference letter; i.e. a former employer. **We require these letters be submitted along with your application packet.**

Academic Reference \_\_\_\_\_  
Address: \_\_\_\_\_

Academic Reference \_\_\_\_\_  
Address: \_\_\_\_\_

*\*If never employed, please provide two additional non-family character or academic references in place of former employer references.*

Former Employer Reference \_\_\_\_\_  
Address: \_\_\_\_\_

Former Employer Reference \_\_\_\_\_  
Address: \_\_\_\_\_

**AS PART OF YOUR APPLICATION, PLEASE REMEMBER TO SUBMIT THE FOLLOWING:**

|  |   |
|--|---|
|  | <p><b>2 (Two academic letters of recommendation</b> (form included) attesting to your academic achievement, goals and character,</p> <p><b>2 (two) former employers reference letters</b> (form included) or <b>personal letters of recommendation from non- family members</b>. Limit to one hand written or typed page.</p> <p><b><u>Each of the 4 recommendation must be submitted in a closed envelope with the writer's signature written across the flap.</u></b></p> |
|  | <p><b>Written essay</b> profiling yourself stressing factors relevant to your occupational choice and goals, qualifications, and motivation you have to pursue your education for your chosen profession as outlined in the application under Line 23 in the first section of this application. Limit it to one 8½” x 11” type-written page (350 words).</p>  |
|  | <p><b>An official high school and/or college transcript.</b> High school transcript needed only if you are entering freshman year or first year of a hospital-based program. Schools must send information directly to OSF Healthcare Saint Elizabeth Medical Center, Human Resources, 1100 E. Norris Drive, Ottawa, IL 61350</p>   |
|  | <p><b><u>Official proof of acceptance into program</u></b> (if not currently enrolled) from the educational institution you will attend.</p>  |

Contact OSF HealthCare Saint Elizabeth Medical Center Human Resources at 815-431-5318 or by email [amy.l.gross@osfhealthcare.org](mailto:amy.l.gross@osfhealthcare.org) if you have any questions.

Application and supporting documents for the Funds must be **postmarked by June 15, 2022.**

**CONSENT FOR RELEASE OF INFORMATION**

“I hereby consent to the release of any information in connection with the foregoing that in the sole judgment of the OSF HealthCare Saint Elizabeth Medical Center & OSF HealthCare Foundation may be of assistance in evaluating my application. I hereby waive any confidentiality with respect to such information in so far as the OSF HealthCare Saint Elizabeth Medical Center & Foundation is concerned, since it is my understanding that the information will be used solely for the evaluation of my application and for no other purpose. The information on this form is, to the best of my knowledge, complete and valid. Any false statement would be cause for termination of any funding. I firmly plan to complete my intended course of study. If I receive an award, I give consent to use my name and photo for publicity purposes.”

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

Date Completed \_\_\_\_\_

**ONLY RECIPIENTS WILL BE NOTIFIED**



**ACADEMIC LETTER OF RECOMMENDATION**

**TO BE COMPLETED BY THE STUDENT:**

NAME OF APPLICANT: \_\_\_\_\_ STUDENT #: \_\_\_\_\_  
 FACULTY NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
 SCHOOL: \_\_\_\_\_  
 MAILING ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_

**I AM APPLYING FOR: OSF HEALTHCARE FOUNDATION LOAN EDUCATIONAL ASSISTANCE PROGRAM FOR HEALTH CAREERS**

I grant permission for the authorities of OSF Healthcare Saint Elizabeth Medical Center & Foundation to investigate my references and release said Medical Center and my (former) instructor from any and all liabilities resulting from such investigation.

\_\_\_\_\_  
**APPLICANT'S SIGNATURE**

\_\_\_\_\_  
**DATE**

**TO BE COMPLETED BY THE FACULTY MEMBER:**

If there is any information which you would prefer discussing personally,  
 you may call Human Resources at 815-431-5318. Please use the boxes below to indicate your assessment of the Student's abilities.

| TRAIT   | SUPERIOR | ABOVE AVERAGE | AVERAGE | BELOW AVERAGE | NO OPPORT. TO OBSERVE |
|---|----------|---------------|---------|---------------|-----------------------|
| <b>PERFORMANCE:</b> Carries out assigned tasks promptly, independently & thoroughly, persevering, industrious.        |          |               |         |               |                       |
| <b>ORIGINALITY:</b> Demonstrates initiative and resourcefulness, uses imagination and is not stereotyped in thinking. |          |               |         |               |                       |
| <b>JUDGMENT:</b> Critically & reliably evaluates facts (people, policies, situations), uses common sense.             |          |               |         |               |                       |
| <b>WRITTEN/ORAL EXPRESSION:</b> Expresses self well orally & in writing.  |          |               |         |               |                       |
| <b>DEVELOPMENT POTENTIAL:</b> Has potential for personal & professional growth.                                       |          |               |         |               |                       |
| <b>LEADERSHIP:</b> Capacity to assume responsibility, organize work & harmoniously execute a project with others.     |          |               |         |               |                       |
| <b>ADAPTABILITY:</b> Ability to evaluate new or changing conditions & accept them naturally.                          |          |               |         |               |                       |

Total number of class days missed \_\_\_\_\_

Total number of clinical days missed \_\_\_\_\_

Student was/is in his/her Freshman \_\_\_\_\_ Sophomore \_\_\_\_\_ Junior \_\_\_\_\_ Senior \_\_\_\_\_ year when he/she was in my class.  
 (Please check all that are applicable.)

Clinical Rotation Course: \_\_\_\_\_

\_\_\_\_\_  
**FACULTY MEMBER'S SIGNATURE**

\_\_\_\_\_  
**DATE**

**EMPLOYER LETTER OF RECOMMENDATION**

**TO BE COMPLETED BY THE STUDENT:**

NAME OF PERSON COMPLETING REFERRAL: \_\_\_\_\_ DATE \_\_\_\_\_

NAME OF BUSINESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NAME OF APPLICANT \_\_\_\_\_

I AM APPLYING FOR: **OSF HEALTHCARE FOUNDATION LOAN EDUCATIONAL ASSISTANCE PROGRAM FOR HEALTH CAREERS**

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\_\_\_\_\_  
APPLICANT'S SIGNATURE DATE

**TO BE COMPLETED BY THE EMPLOYER:**

If there is any information which you would prefer discussing personally,  
you may call Human Resources at 815-431-5318. Please use the boxes below to indicate your assessment of the Student's abilities.

POSITION HELD: \_\_\_\_\_ FULL TIME: \_\_\_\_\_ PART TIME: \_\_\_\_\_

DATES OF EMPLOYMENT :From: \_\_\_\_\_ to \_\_\_\_\_

REASON FOR LEAVING: \_\_\_\_\_

|  | EXCELLENT | GOOD | SATISFACTORY | UNSATISFACTORY | REMARKS |
|--|-----------|------|--------------|----------------|---------|
| Quality of Work                        |           |      |              |                |         |
| Quantity of Work                       |           |      |              |                |         |
| Attendance & Punctuality               |           |      |              |                |         |
| Attitude                               |           |      |              |                |         |
| Responsibility                         |           |      |              |                |         |
| Communicative Ability (Oral & Written) |           |      |              |                |         |
| Overall Rating                         |           |      |              |                |         |

WOULD YOU RE-EMPLOY: YES: \_\_\_\_\_ NO: \_\_\_\_\_ EXPLANATION: \_\_\_\_\_

ADDITIONAL COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE/TITLE DATE