Attached is an application for the **Houston Healthcare – Warner Robins Auxiliary/Perry Auxiliary/ Virginia Wetherington scholarship.** The Auxiliary will be awarding $1,000 scholarships to selected Seniors attending one of the following schools:

- **Houston County High School**
- **Northside High School**
- **Warner Robins High School**
- **Veterans High School**
- **Perry High School**

The student must plan to pursue a career in health care. A transcript of grades for his/her Junior and Senior years must be attached to the application along with three (3) letters of reference.

Completed application must be received by **March 17, 2025,** to qualify for consideration.
You may mail or email your completed application package to:

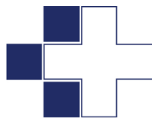
Mail: **Houston Healthcare – Warner Robins**
HMC Scholarship Committee
c/o Volunteer Services
1601 Watson Boulevard
Warner Robins, GA 31093

Email: **Scholarships@hhc.org**

Please feel free to make additional copies of the application. If you have any questions, please feel free to contact the **Volunteer Services Office** for Houston Healthcare – Warner Robins at **(478) 542-7753**.

Sincerely,

Houston Healthcare - Warner Robins Auxiliary



HOUSTON HEALTHCARE

SCHOLARSHIP APPLICATION

Houston Healthcare – Warner Robins Auxiliary/Virginia Wetherington Scholarship

Houston Healthcare – Warner Robins Center Auxiliary

Name:____ Sex (circle one): M / F
Last First M.I.

Street: _______________________________________ Phone: ____________________

City: ________________________________ State: _______ Zip: ___________

Date of Birth: ___ / ___ / ______ Place of Birth: ______________________________

Father’s name in full: ____________________________ Living?: _________

Present address: ____

Present occupation: ____

Mother's name in full: ____________________________ Living?: _________

Present address: ____

Present occupation: ____

If you live with someone other than your parents, please fill in following:

_____________________________________ ______________________
Name Relationship

_____________________________________ ______________________
Address Phone Number

Schools Attended:

Name	City/State	Dates	GPA
____________________	_____________________	______________	_______

____________________ ____________________ ______________ _______

What courses did you study in high school toward a medical career?

____

Have you taken the SAT? _______ Scores: ________________________________

Scholarship Application

What types of activities, clubs, and services have you participated in during your high school years? ____

____

____

What awards or honors have you received? ________________________________

____

Give the names and addresses of three adults - not relatives - who know you and who can give information about you. *(You may include teachers, counselors, employers, ministers, etc...)*

Name	Address & Phone #	Position
1: ______________________	______________________	__________
2: ______________________	______________________	__________
3: ______________________	______________________	__________

Name of school you plan to attend: ____

Have you applied and been accepted? Y / N If yes, start date: __________________

Course of study: ____

Length of time to complete degree: ______________________________________

Do you anticipate any complications with family or other responsibilities that could interfere with your pursuit of this degree? Y / N

If yes, please explain: ____

____

What is your ultimate goal? ____

____

Please complete the following: *(Use additional sheet, if needed.)*

A. Reasons for selecting this career:

B. Work experiences (include volunteer work):

C. Reasons for entering chosen school:

D. Other statements that would indicate attitude and interests in this career:

E. Have you applied for other scholarships? If so, list scholarship name(s) and whether or not you have been selected.

STUDENT'S CERTIFICATION

I declare that the information reported is true, correct and complete.

____ ______________________

Signature Date

SCHOLARSHIP AGREEMENT

It is agreed that:

1. The decision of the scholarship committee's award is final;
2. Further personal and/or financial information will be provided if the committee requires it;
3. Scholarship funding is to defray the cost of all or part of tuition and will be paid directly to the college;
4. In the event that the student ceases course study in related health field, scholarship funding will no longer apply;
5. Scholarship money will be sent to the college once a confirmation from the registrar's office of the course/class schedule is received.

I have read and clearly understand the above agreement:

Student Signature	Date	Witness
Parent/Guardian Signature	Date	Witness

Note:

- ***Transcripts required*** *- Each applicant must assure that a transcript (for Junior and Senior Year) is included with package -or- mailed to the address below.*
- ***Letters of reference*** *- Applicant must also have three (3) letters of reference attached to the application.*
- ***Applications will not be accepted if any areas are incomplete.***
- ***Deadline*** *– the receipt deadline for all information is* ***March 17, 2025, by 4pm.***

You may mail or email your completed application package to:

Mail: **HMC Scholarship Committee**
c/o Volunteer Services
Houston Healthcare – Warner Robins
1601 Watson Blvd.
Warner Robins, GA 31093

Email: **Scholarships@hhc.org**