Auxiliary of
HSHS
St. Anthony's
Memorial Hospital

HSHS ST. ANTHONY'S MEMORIAL HOSPITAL AUXILIARY SCHOLARSHIP GUIDELINES

- ✓ The applicant must attend an accredited **Illinois** college working toward a degree/license/certification related to a healthcare related field.
- ✓ The Scholarship Committee reserves the right to make judgment in cases not covered by the guidelines.
- ✓ Students must have a grade point average of 2.0 or higher. Transcript required for most current year.
- ✓ Payment of all scholarships are made to the college, upon receipt of verification of enrollment.
- ✓ *Scholarship applications must be postmarked by* ***March 15, 2025***.
- ✓ All applications will receive a letter by May 1 indicating whether or not they are the recipient of the scholarship.
- ✓ A photo must be attached to the cover page of the application, and photo consent signed. These photos will be used by the HSHS St. Anthony's Memorial Hospital Auxiliary for publicity purposes. If an applicant is not accepted for a scholarship, the photo will be returned.
- ✓ If for any reason the applicant is unable to enroll, the awarded scholarship will not be remitted, and may be awarded to another applicant.
- ✓ A representative from HSHS St. Anthony's Memorial Hospital will receive the application--keeping the cover page until the scholarship winners have been chosen so that the Scholarship Committee will not know the identity of the applicants until after the selection has been made.

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APPLICATION FOR HSHS ST. ANTHONY'S MEMORIAL HOSPITAL AUXILIARY SCHOLARSHIP

Please type or print clearly.

The completed application must be postmarked by March 15, 2025 and sent to:

HSHS St. Anthony's Memorial Hospital
ATTN: Auxiliary Scholarship
503 N. Maple Street
Effingham, IL 62401

Date of Application: _____

Name of Applicant: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

E-Mail Address: _____

*Please attach a recent photo to this page.

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APPLICATION FOR HSHS ST. ANTHONY'S MEMORIAL HOSPITAL AUXILIARY SCHOLARSHIP

(Additional sheets may be used)

List names of high school(s) attended and number of years at each:

_____

Name and address of Illinois college you plan to attend:

_____

_____

Name of course of study or major you plan to take:

_____

What license, certificate, or degree is granted on completion?

_____

What are your employment goals/plans?

_____

_____

List other honors/awards received, if applicable:

_____

_____

List school/extracurricular/community activities:

_____

_____

_____

List work experience:

_____

_____

Please attach the most current grade transcript (for current high school/college students)

Please provide two (2) non-family letters of recommendation.

Please attach a short essay (approximately 150 words) stating your educational goals and how this scholarship will help you attain these goals.

Hospital Sisters HEALTH SYSTEM | PREVEA health

Authorization to Photograph/ Video Record/Interview and/or Use and Disclose Protected Health Information for Marketing/Communications

Name of "Subject": _____

Address: _____

Phone/Email: _____

Marketing Material: Marketing Material may include video images, photographic images, conversations, sounds, audiotapes, verbal and/or written testimonials, statements, biographical information and/or protected health information (including but not limited to name and disease state). Other (list additional marketing material): _____

Purpose: Use and disclosure for marketing and promotional purposes, including but not limited to, publication in newspapers, magazines, patient information material, television, intranet, internet advertisements, educational or social media platforms, and other public mediums or in any other advertisement on behalf of the Organization and its affiliates, including but not limited to, the Organization's charitable Foundation. Other: _____

Authorization: I hereby authorize the "Organization" checked below to acquire "Marketing Material" pertaining to Subject and allow use and disclosure for the Purpose as stated above (check the box of all organizations that apply):

Wisconsin:

- ☐ St. Vincent Hospital
- ☐ St. Nicholas Hospital
- ☐ Sacred Heart Hospital
- ☐ Libertas Treatment Ctr
- ☐ St. Mary's Hospital Medical Ctr
- ☐ St. Clare Memorial Hospital
- ☐ St. Joseph's Hospital
- ☐ Prevea Health

Illinois:

- ☐ St. John's Hospital
- ☐ St. Elizabeth Hospital
- ☐ St. Francis Hospital
- ☐ Good Shepherd Hospital
- ☐ Holy Family Hospital
- ☐ Prairie Cardiovascular Consultants
- ☐ St. Mary's Hospital
- ☑ St. Anthony's Memorial Hospital
- ☐ St. Joseph's Hospital - Breese
- ☐ St. Joseph's Hospital - Highland
- ☐ Medical Group

Limitations: Marketing Material shall not include the following (identify limitations, if any): _____

_____

I, Subject, understand that:

1. This authorization is strictly voluntary.
2. This authorization doesn't expire, and I may revoke it at any time in writing. A revocation will not have any effect on any actions taken by Organization or recipient in reliance upon the authorization prior to receiving my revocation. A description of how to revoke the authorization is located in the Organization's Notice of Privacy Practice.
3. The Marketing Material may be subject to further disclosure by recipients and no longer protected by law.
4. Whether I sign this authorization or not, my health care, payment, enrollment or eligibility for benefits will not be affected.
5. I may obtain a copy of the Marketing Material if I ask for it. **By signing this authorization, I am waiving my right to inspect or approve the publication or dissemination of the Marketing Material or to receive any compensation regarding the use of the Marketing Material by the Organization for the Purpose.**
6. This authorization shall act to release the Organization and its agents and employees from any liability connected with the Marketing Material for the Purpose to the maximum extent permitted by law.
7. A photocopy of this authorization shall have the same force and effect as the original.

Signature of Subject: _____ Date: _____

If Subject is unable to sign, complete the following: (check all that apply)

- ☐ Individual is a minor, legally incompetent or incapacitated
- ☐ Signatory has legal authority to sign (i.e., a parent*, legal guardian, or activated POA for Health Care)

Name of legal authority: _____
Address: _____
Phone/Email: _____

Signature of legal authority: _____

*By signing above, I hereby declare that I have not been denied physical placement of this child.