



HOUSTON HEALTHCARE

Perry High School
1307 North Avenue, #2614
Perry, GA 31069

Attached is the application for the Perry Hospital Auxiliary/Audrey Cason Scholarship. The Auxiliary will be awarding a \$1,000 scholarship to one graduating Senior at 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 3 letters of reference.

Due to the uncertainty of when it will be deemed to be 'safe practice' to meet in person, it is most likely the interviews will take place via telecom methods.

Please send all information by **March 26, 2021**

Perry Hospital
c/o Michelle Martin
Patient Relations Coordinator
1120 Morningside Drive
Perry, GA 31069

If you have any questions, please feel free to contact me.

Sincerely,
Tina Meyers
Perry Hospital Auxiliary
Scholarship Committee Chairperson
(478) 302-7120

HOUSTON MEDICAL CENTER
1601 Watson Boulevard
Warner Robins, Georgia 31093
(478) 922-4281

PERRY HOSPITAL
1120 Morningside Drive
Perry, Georgia 31069
(478) 987-3600

HOUSTON HEALTHCARE SCHOLARSHIP APPLICATION

for the

Audrey Cason Scholarship

Perry Hospital Auxiliary

Name: _____ Sex: M F
Last First MI

Street: _____ Phone: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Place of Birth: _____

Father's Full Name: _____ Living? _____

Present Address: _____

Occupation: _____

Mother's Full Name: _____ Living? _____

Present Address: _____

Occupation: _____

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

Name: _____ Relationship: _____

Address: _____ Phone: _____

Schools Attended:

Name of School	City/State	Dates Attended	GPA
_____	_____	_____	_____
_____	_____	_____	_____

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

Have you taken the SAT? Y or N Scores _____

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

What awards or honors have you received? _____

Please provide the names and addresses of three adults, not related to you, who know you and can provide information about you. (You may include teachers, counselors, employers, clergy, etc.)

Name	Address & Phone Number	Position
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1. _____

2. _____

3. _____

Name of the school you plan to attend: _____

Have you applied and been accepted? Y or N Starting date: _____

Course of Study: _____

Length of time needed to complete degree: _____

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

If so, please explain: _____

What is your ultimate goal? _____

Please complete the following (use additional sheets, as needed)

A. Reasons for selecting this career: _____

B. Work Experience(s) (include volunteer work): _____

C. Reasons for the school chosen: _____

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

E. Have you applied for other scholarships? If so, indicate name and whether or not you have been selected. _____

Student Certification

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

Name: _____

Signature

Date

SCHOLARSHIP AGREEMENT

It is agreed that:

1. The decision of the scholarship committee 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 the tuition and will be paid directly to the school or college.
4. In the event the student fails to register in a health related field, the scholarship funding will no longer be awarded.
5. Scholarship will be awarded in one lump sum of \$1,000.00 directly to the school the student is attending.

I have read and clearly understand the above agreement:

Student Signature	Date	Witness
Parent Signature	Date	Witness

NOTE: Each applicant must ensure that a transcript (for both Junior and Senior years) is attached to this application.

Applicant must also have three (3) letters of reference attached to the application. The application must be submitted no later than 4 p.m. on 26 March 2021. Applications not completely filled out or missing attachments will not be accepted.

**Please submit the application package to Perry Hospital Scholarship Committee
Attn: Michelle Martin
Patient Relations Coordinator
1120 Morningside Drive
Perry, GA 31069**