Olympic Medical Center Foundation Scholarship Criteria
For Peninsula College Clinical Nursing Program
Non-Olympic Medical Center employees

Olympic Medical Center Foundation Scholarship supports ongoing education and professional development of individuals pursuing education in the medical field. The Olympic Medical Center Foundation Scholarship has been created to benefit the medical community by supporting individuals seeking to pursue educational opportunities in healthcare to improve their lives and the lives of patients within Clallam County.

The Olympic Medical Center Foundation Scholarship shall provide funding for individuals, at their discretion, to cover expenses leading to a medically related degree, certificate, or course of study.

At the discretion of the Committee, awards will vary based on the costs of the program, the type of program, the resources of the applicant, and materials provided to the scholarship committee.

Applications will be accepted on a rolling basis and awards shall be distributed based on program payment obligations.

SCHOLARSHIP CRITERIA

To be considered for a scholarship, Applicants must meet the following criteria and submit the below listed documentation:

1. Applicant must be a current resident of Clallam County.

2. Applicant must express interest in pursuing and obtaining education supporting community needs in medical care.

3. The applicants proposed educational program shall be a medically related program, degree or certificate and, if possible, ACEN, CCNE, or nationally or regionally accredited. The applicant shall provide the proposed completion date.

4. The applicant shall provide monthly household income and expenses. Please see attached Personal Budget Form.

5. The application should include the total cost of the program and provide a detailed listing of all educational expenses expected to be incurred over the following year including tuition, fees, books, supplies, and other required materials.

6. The applicant shall provide academic history including grades, or transcript if available. Applicant may explain any incomplete programs of study.

7. The applicant must submit a one-page narrative stating how the proposed educational program will impact their personal contribution to the organization, reasons for their chosen course of study, why there is a need for financial assistance for school, and how the proposed educational program contributes to Olympic Medical Center.

8. The applicant shall provide a letter of recommendation, preferably from the applicant's supervisor, teacher, professor, or other life mentor.

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Olympic Medical Center Foundation Scholarship Information Form

Date ____

Applicant's Legal Name

First ______________________________Last ___________________________________

Middle____________________________

Contact /Phone Number____

Email ____

Physical Address____

Mailing Address____

Married/Single_____________________________________

Number of dependents _______________________________

Are you currently an Olympic Medical Center employee? Y/N
If yes, what is your position? ____

Do you currently have a college degree? Y/N ______________________________________
If yes, please list.
____

Are you currently enrolled or have you been accepted into a college/university?
Y/ N
If yes, program of study/degree
____
College/ University Name
____

If different than above, please list college/ university you are wanting to attend.
____

Program is based on semester/quarter ____

Number of semesters/ quarters completed_______________________________________

Number of semesters/ quarters still needed to complete desired program.
____

Student ID Number ____________________________________

Current GPA____

If applicable, have you been accepted into the Peninsula College Nursing Program? Yes/ No
____

Have you been awarded an Olympic Medical Center Foundation Scholarship in the past?

Yes/ No_____________________

If yes, Date____________________________

Scholarship amount. $____________________

Tuition amount $ _______________________

Living expenses amount $_________________

Have you been awarded any other scholarships, grants or funding for your desired program of study?

Yes/ No____________________

If yes, please list the institution proving the scholarship and the amount awarded.

Institution name ____

Amount Awarded________________________________

SCHOLARSHIP APPROVAL

Available scholarship funds will be granted to recipients in denominations as decided by and at the discretion of the Olympic Medical Center Foundation.

Upon scholarship selection Applicant shall:

1. Scholarship recipients shall sign an agreement to pursue employment at OMC/OMP for a period of at least two years, based on operational need, following receipt of the most recent scholarship payment or re-pay the amount of the scholarship in full.

2. Scholarship recipients shall maintain a good standing with the educational program and/or institution.

3. Scholarship recipients shall provide documentation to support all expenses for which reimbursement is requested. Direct payment to the school is preferred. Covered items include course tuition, fees, books, supplies, and equipment required by the course syllabus. The cost of a computer is not covered. Original invoices and receipts must be submitted to the Olympic Medical Center Foundation. The Olympic Medical Center Foundation can reclaim any unused funds at the end of the student's semester or school year.

4. Scholarship recipients understand that neither this agreement nor any other communication by administration, any representative or any other employee, whether oral or written, is intended in any way to create a contract of employment. Scholarship recipients will be employed at will and this agreement does not modify at-will employment status.

*Equal Opportunity and Nondiscrimination: Olympic Medical Center is enriched by the many experiences and perspectives each individual member brings to our community. Olympic Medical Center Scholarship Foundation does not discriminate admissions, employment, or in any of its educational programs or activities on the basis of race, color, national or ethnic origin, ancestry, age, religion, disability, sex or gender (including pregnancy, sexual harassment and other sexual misconduct including acts of sexual violence such as rape, sexual assault, stalking, sexual exploitation, sexual exploitation and coercion, relationship/intimate partner violence and domestic violence), gender identity and/or expression (including a transgender identity), sexual orientation, military or veteran status, genetic information, the intersection of these identities or any other characteristic protected under applicable federal, state or local law

**Please note Scholarships may or may not be taxable income and applicants are strongly encouraged to review IRS Publication 520 Scholarships and Fellowships or consult with a tax professional.

Applicant's Legal Name________________________

Date_________________

Application Checklist

Below is a checklist of items to be submitted with the application.

Once the application is complete, please forward the packet electronically to andrea@omhf.org

- ☐ Copy of Monthly income and expenses
- ☐ Copy of anticipated costs or expenses from your specific institution
- ☐ Anticipated Educational Expense (tuition, books, etc.)
- ☐ Academic history – transcripts, grades etc.
- ☐ A one-page narrative stating how the proposed educational program will impact their personal contribution to the organization, reasons for their chosen course of study, why there is a need for financial assistance for school, and how the proposed educational program contributes to care of medical patients in Clallam County
- ☐ The applicant shall provide a letter of approval from the applicant's immediate supervisor/director/manager or other leader/mentor/educator.
- ☐ The applicant is willing to sign an agreement to pursue employment at OMC/OMP for at least two years of employment.

The applicant will be notified in writing of determination.

Applicant signature to acknowledge and agree to the conditions on page 1-6.

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Applicant's Legal Name______________________________________

Date______________________

Personal Budget

Personal Income

A. Gross Monthly Income	
Monthly Wage and Salary	
Income from Interest	
Income from business	
Other Income	
Total Gross Monthly Income (add all lines above)	
Total gross income for this year before deductions (starting January 1 of this year until now)	
B. Monthly Deductions	
Income taxes (federal and state)	-
FICA (Social Security + Medicare) or self-employment taxes	-
State Industrial Insurance (Workers' Comp.)	-
Mandatory union or professional dues	-
Mandatory pension plan payments	-
Voluntary retirement contributions (up to the limit in RCW 26.19.071(5)(g))	-
Normal business expenses	-
Total Monthly Deductions (add all lines above)	-

C. Monthly Net Income	
1. Total Gross Monthly Income (from A above)	
2. Total Monthly Deductions (from B above)	-
3. **Net Monthly Income** (Line 1 minus Line 2 in C)	

D. Household	
1. Income of other individuals in household	
2. Number of household members	-

Applicant's Legal Name____

Date______________________

PERSONAL BUDGET (con.)

PERSONAL AND OTHER MONTHLY EXPENSES

A. Housing Expenses		**E. Transportation Expenses**	
Rent / Mortgage Payment		Automobile payment *(loan or lease)*	
Property Tax (if not in monthly payment)	-	Auto insurance, license, registration	
Homeowner's or Rental Insurance	-	Gas and auto maintenance	
Other mortgage, contract, or debt payments based on equity in your home	-	Parking, tolls, public transportation	-
Homeowner's Association dues or fees	-	Other transportation expenses	-
Total Housing Expenses		**Total Transportation Expenses**	

B. Utilities Expenses		**F. Personal Expenses**	
Electricity and heating (gas and oil)	-	Clothes	
Water, sewer, garbage	-	Hair care, personal care	
Telephone(s)	-	Recreation, clubs, gifts	-
Cable, Internet	-	Education, books, magazines	
Other *(specify)*:	-	Other Personal Expenses	-
Total Utilities Expenses		**Total Personal Expenses**	

C. Food and Household Expenses		**G. Other Expenses**	
Groceries for *(# of people)*		Life insurance (not deducted from pay)	-
Household supplies (cleaning, paper, pets)		Other *(specify)*:	-
Eating out	-	Other *(specify)*:	-
Other *(specify)*:	-	Other *(specify)*:	-
Total Food and Household Expenses		**Total Other Expenses**	

D. Children's Expenses		**H. Health Care Expenses**	
Childcare, babysitting		Insurance premium (health, vision, dental)	
Clothes, diapers	-	Health, vision, dental, orthodontia, mental health expense not covered by insurance	
Tuition, after-school programs, lessons		Other health expenses not covered by insurance	
Other expenses for children	-	**Total Health Care Expenses**	
Total Children's Expenses	**-**		

I. All Total Expenses (add A - E above)

Applicant's Legal Name____

Date_______________________

PERSONAL BUDGET (con.)

ASSETS

List *your* liquid assets, like cash, stocks, bonds, that can be easily cashed.	
Cash on hand and money in all checking & savings accounts	
Stocks, bonds, CDs and other liquid financial accounts	-
Scholarship Awards/ Amounts (List Organization) _______________________________________	
Financial Aid (List Organization) _______________________________________	
Cash value of life insurance	-
Other liquid assets	-
Total Available Assets (add all lines above)	

DEBTS

Describe Debt *(credit card, loan, etc.)*	Who do you owe *(Name of creditor*	Amount you owe this creditor now	Last Monthly Payment *(Date and Amount*	
				$
		-		-
		-		-
		-		-
		-		-
		-		-
			Total Monthly Payments for Debts	

Applicant's Legal Name____

Date_______________________

ANTICIPATED EDUCATION EXPENSES

Anticipated Education Expenses

Tuition Costs Per Semester/ Quarter	
Tuition	
Books	-
Lab Fees	-
Other (please list)	-
Total Anticipated Expenses *Please attach a copy of costs and fees from your specific school or institution.	

AGREEMENT TO PAYBACK SCHOLARSHIP FUNDS OMC non-employee

The following is to be read and signed by the scholarship awardee.

I ____________________________________ agree to:

- Remain enrolled and in good standing with the educational institution and program of study
- Provide required documentation as requested/required by Olympic Medical Center Foundation

Upon successful completion of the program, awardees receiving scholarship assistance under Olympic Medical Center Foundation Scholarship program must agree to provide two years of uninterrupted employment to Olympic Medical Center. <u>You agree to repay this financial assistance should you terminate your employment before the agreed upon two years of service to Olympic Medical Center Foundation.</u>

I have read and understand the information contained in this document and agree to comply with the above provisions and the requests made by the Olympic Medical Center Foundation Scholarship Fund/Committee.

I understand that neither this agreement nor any other communication by Olympic Medical Center Foundation Scholarship, Olympic Medical Center administration, any representative or any other employee, whether oral or written, is intended in any way to create a contract of employment. Any offer of employment is at will and this agreement does not modify any at-will employment offer. Employment is not guaranteed, nor does this create an expectation of employment. Employment is contingent upon meeting the conditions for hire and organizational needs.

______________________________	______________________________
Scholarship Awardee Printed Name	Administrator, OMC Foundation
______________________________	______________________________
Scholarship Awardee Signature	Date
______________________________	______________________________
Date	Assistant Administrator, OMC
` ______________________________	______________________________
	Date