2010 Health Campus Drive
Harrisonburg, VA 22801
(540) 689-1180

Diversity in Healthcare Scholarship Program

STUDENT INFORMATION

Student's Name_____Today's Date_____

Permanent Address_____

_____Home Phone_____

Cell phone_____ Email_____

HIGH SCHOOL/COLLEGE INFORMATION

Name of High School_____Graduation Year_____

Address_____Phone Number _____

Name of College or University_____Graduation Year_____

Address_____Phone Number_____

Have you been accepted into a healthcare related program of study? _____Yes _____No

Anticipated college graduation date _____

DEMOGRAPHIC INFORMATION

Race:
❒ American Indian or Alaska Native ❒ Asian or Pacific Islander ❒Black ❒Hispanic
❒ White ❒ Other_____

Ethnicity/Nationality: _____

DIVERSITY ATTRIBUTES

Language(s) spoken_____

Proficient in culture(s) _____

Diverse Background_____

Community or co-curricular involvement with diverse populations: _____

_____

_____

TYPE OF PROGRAM YOU ARE OR WILL BE ATTENDING (CHECK ONE):

Nursing
❒ Bachelor's Degree ❒ Associate Degree

Respiratory Therapy
❒ Certified Respiratory Therapy Technician ❒ Registered Respiratory Therapist

Laboratory
❒ Medical Technologist

Radiology
❒ Technologist

Surgical
❒ Surgical Technologist

Pharmacy
❒ **Pharmacist**

Physical Therapy
❒ Physical Therapist ❒ Physical Therapist Assistant
❒ Occupational Therapist ❒ Occupational Therapist Assistant

Cancer
❒ Radiation Therapist

Other
Please Specify: _____

APPLICATION REQUIREMENTS

Applications cannot be completed until all of the items listed below have been received. Check here if you have arranged to have the following information sent to us:

❒ High school transcript

❒ Educational health career program curriculum outline

❒ College transcript (if applicable)

❒ Recommendation letter (from teacher/professor/guidance counselor/advisor)

❒ Essay on why you are applying for the Diversity in Healthcare Scholarship (2 pages)

❒ Letter from the health career school you are or will be attending, stating that you have been admitted to the clinical phase of the program and the anticipated date of graduation (if applicable).

List other loans, grants or financial awards toward your education expenses.

_____

_____

Mail to:
RMH Healthcare
Att: Silvia Garcia-Romero
2010 Health Campus Drive
Harrisonburg, VA 22801

APPLICANT'S AGREEMENT AND CERTIFICATION

I certify that the information given by me in this application is true in all respects, and I agree that if the Scholarship is granted and the application is found to be false in any way that I may be subject to repayment without notice, if and when discovered. I authorize the use of any information in this application to verify my statements, and I authorize the past employers, doctors, all references and the other persons to answer all questions asked concerning my ability, character, reputation and previous employment record. I release all such persons from any liability or damage on account of having furnished such information.

_____ _____

Signature of Applicant Date