SARA D. HANES MEMORIAL SCHOLARSHIP

Information Sheet

This scholarship is for a student who is currently studying within the medical field.

Scholarship funds are to be utilized exclusively for educational expenses in an accredited Georgia school by a Georgia resident.

Student must have a grade point average of 3.0 or higher as reflected in an official transcript.

Deadline is May 15, 2025, for consideration for the next school year.

The student's COMPLETE application must include

1. Completed APPLICATION FORM – four pages

2. Three letters of recommendation on appropriate letterhead. Each must be signed and dated. **One must be from a teacher.** The other two must be from someone who knows the student well and can attest to his/her qualifications.
Example − volunteer coordinator, supervisor, pastor, mentor, employer (*BUT no family members*).
There are three (3) forms included with the application to be given to each person who is writing your recommendation.
These letters are to be mailed directly to the Scholarship Committee *FROM THE PERSON* making the recommendation.

3. Official transcript

HAVE YOUR CURRENT SCHOOL SEND AN OFFICIAL TRANSCRIPT DIRECTLY TO US.
(Faxes or photocopies are not acceptable.)

All paperwork must be MAILED and POST-MARKED by May 15, 2025.
Anything HAND-DELIVERED will NOT be accepted.

Mailing address −

Piedmont Walton Hospital Auxiliary
Auxiliary Scholarship Committee
2151 West Spring Street
Monroe GA 30655

SARA D. HANES MEMORIAL SCHOLARSHIP

Letter of Recommendation Form

The purpose of this scholarship is for a student who is currently studying within the medical field, is a Georgia resident, is currently attending an accredited school in Georgia, and has a grade point average of 3.0 or higher.

PLEASE PRINT OR TYPE

Scholarship Applicant's Name _____

Your Name _____

Your street address _____

City _____ State _____Zip code_____

Your phone number(s) Home/work (_____)_____ Cell (____) _____

Your email address _____

How long have you known the applicant? _____

In what capacity do you know the applicant? _____

May we contact you if we have any additional questions about the applicant? Yes ____ No ___

On appropriate letterhead we would appreciate your opinion of the applicant. We ask that while considering the applicant, you strongly consider his/her kindness and love for others and how the applicant displays those qualities in his/her life. Please include any information on qualities that set this applicant apart from his/her peers and would make him/her a worthy recipient of this scholarship. This award is based on the applicant's merit only. Financial need is not taken into consideration.

When your letter is completed, please sign and date, and place the letter **AND** this form in an envelope, and mail directly to the Scholarship Committee at the address below. **It must be MAILED and POSTMARKED by May 15, 2025. Hand-delivered letters will not be accepted.**

Thank you for your time!

Piedmont WALTON

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Auxiliary Scholarship Committee
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APPLICATION FORM

Please print or type. All lines must be completed. Use N/A when not applicable.

First name_____MI ___ Last name _____

Date of birth _____ Social Security Number _____

Current street address _____

City_____ State ____ Zip code_____

Phone number(s) Home/Work (_____)_____ Cell (_____)_____

Email address _____

Name of the school you currently attend _____

School street address _____

City_____ State _____ Zip code_____

Phone number (_____)_____

List the three most recent jobs (beginning with the current or most recent) you have held.

EMPLOYER DUTY DATES FULL/PART TIME

_____

_____

_____

Excluding your current school, in chronological order list all attended beginning with high school.

NAME LOCATION DIPLOMA/DEGREE

_____

_____

_____

_____

What honors (academic or otherwise) have you received and when?

_____

_____

_____

_____

Why are you considering a healthcare profession?

_____

_____

_____

_____

What is your current course of study? _____

Present academic level _____

Cumulative grade point average _____

What health or science related fields or activities have you been involved in, either for recreation or as a volunteer?

_____

_____

_____

_____

Name of school and address of FINANCIAL AID OFFICE

_____

_____

_____

Will you be a full or part-time student? _____ Expected graduation date _____

Please describe why you think you should be considered for this scholarship. What makes you stand out from all the other applicants to be granted this scholarship?

_____

_____

_____

_____

_____

_____

_____

_____

SARA D. HANES MEMORIAL
SCHOLARSHIP AGREEMENT

It is agreed that−

The applicant is to be currently studying within the medical field.

Scholarship funds are to be utilized exclusively for educational expenses in an accredited Georgia school.

Student must have a grade point average of 3.0 or higher as reflected in an official transcript.

The decision of the Scholarship Committee's award is final.

Only the winner of the scholarship will be notified.

I have read and understand the above agreement.

Applicant's
Signature _____ Date _____

Print name _____