



**COMMUNITY MEDICAL CENTER  
BOARD OF DIRECTORS SCHOLARSHIP  
APPLICATION**

Two scholarships in the amount of \$1,000 each are awarded annually to students who are graduating from a high school in Richardson County, Nebraska or State Approved Home School. Scholarships will be awarded to those entering a two- or four-year college with a declared major in the healthcare field. Scholarship winners will be eligible to renew the scholarship for one (1) additional year if they maintain a 3.0 GPA and retain a healthcare major.

All eligible applicants will be evaluated using a standardized scoring system. It is the applicant's responsibility to ensure the scholarship application is completed in its entirety and contains all required components. Incomplete applications or applications received after the deadline will be considered ineligible and will not be evaluated.

Applications should be completed and returned to Community Medical Center, Attn. Human Resources, PO Box 399, Falls City, NE 68355, by **April 7, 2025**.

**SECTION I: Demographic Information**

**Please supply the following information to complete the application.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Parents Name: \_\_\_\_\_

College in Which Enrolled: \_\_\_\_\_

Expected College Major: \_\_\_\_\_

High School: \_\_\_\_\_

Total Number in Class: \_\_\_\_\_ Rank in class: \_\_\_\_\_

***Signature of Guidance Counselor:*** \_\_\_\_\_



**SECTION II: Activities and Awards (attach one additional sheet if necessary)**

**ACTIVITIES:** Involvement in School, Church, and Community Activities: (List and state offices held).

**HONORS, AWARDS, SCHOLARSHIPS:** (Academic, Athletic or Service)

**SECTION III: Letters of Recommendation**

Provide two letters of recommendation. One of the letters must be from an individual outside of the academic arena.

**SECTION IV: Personal Statement**

Attach a one page or less narrative explaining your goals and why you are choosing to enter the healthcare field.

**SECTION V: Official Transcript**

Attach an official transcript of grades including SAT/ACT scores.



**SECTION VI: Applicant Signature**

I certify that the information contained in this application is true, complete, and correct the best of my knowledge. I hereby authorize Community Medical Center to release my name, picture, scholastic information, and course of study to the Falls City Journal if I am awarded the scholarship.

Signature of applicant: \_\_\_\_\_ Date: \_\_\_\_\_



3307 Bill Schock Boulevard  
P.O. Box 399  
Falls City, NE 68355-0399  
402-245-2428  
www.cmfc.org

## Media Consent Form

I consent to Community Medical Center, Inc. (CMC) interviewing, photographing, audio recording, or videotaping me and/or my child(ren) and using these stories, testimonials, quotes, images, audiotapes, or videotapes to produce the following content: printed materials such as posters or newsletters; electronic media campaigns for the CMC website and social media pages; or for television or radio programs (collectively, the "materials"). The materials are used to promote the activities of CMC.

I have the right to request a copy of the interview transcripts, recordings, films or other images prior to or during the production of the materials. I understand that I will not have editorial control over the production of the materials. I understand I do not have any ownership rights to the materials produced. I have had the opportunity to ask questions about the potential uses of the materials to be produced and published.

I have the right to change my mind at any point during the planning, production, or use of the materials. However, I must notify CMC to inform them that I no longer consent to the use of my and/or my children's interviews, photographs, audio recordings or videotapes. If CMC has already used the materials, it will immediately stop using the materials after I withdraw my consent.

I am at least 19 years of age, and I am competent to sign this form in my own name, or I am the parent/legal representative of the subject whose name appears below and I consent to these conditions. I have read this form and understand its contents.

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Signature of Patient or Legal Representative

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Date

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Printed Name

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Relationship to Patient if signed by Legal Representative



## **Scholarship Application Checklist**

- Section I completed in its entirety, including the signature of a guidance counselor.
  
- Comprehensive list of all activities participated in, and awards received.
  
- Two letters of recommendation, including one from an individual outside the academic arena.
  
- Personal statement explaining your goals and why you are choosing to enter the healthcare field.
  
- Official transcript including SAT/ACT scores.
  
- Media consent form.