

FRANK & SHIRLEY DICK HEALTH SCHOLARSHIP

ELIGIBILITY

1. The candidate must be a graduating senior from a Lenawee County school.
2. The candidate must be accepted for attendance at an accredited trade school, community college, or baccalaureate degree granting institution of higher education.
3. The candidate must be seeking a degree in a health related field.

OTHER CONSIDERATIONS

1. An applicant for the Frank & Shirley Dick Scholarship shall not be the son or daughter of an employee or member of the Board of Education of the Lenawee Intermediate School District, nor of a Trustee of the Lenawee County Education Foundation, or an employee of Gleaner Life Insurance Society.
2. This scholarship will be for one year in length.
3. The amount of the scholarship will be \$1,000 per award.
4. The scholarship will be paid jointly to the student and the institution with one-half payment being made each semester, providing the student continues his/her formal education into the second semester.

GENERAL INSTRUCTIONS

1. Applications and statements must be typewritten and signed in all instances.
2. Official high school are required from the beginning of the 9th grade up to the due date of the application. Transcripts may be photocopied provided the school authorizes it.
3. The application should be prepared and arranged in the following order:
 - a. Completed and signed application.
 - b. Essay which is 200-300 words in length discussing his/her goals in the field of health care and relate how past, present, and future involvement makes the accomplishment of this goal probable.
 - c. A letter of recommendation from a high school counselor or other educator should accompany the application.
 - d. High school transcripts and college admission test scores (ACT).
4. Deadline for submitting the application is the second Friday in March.

Mail or deliver to: Lenawee County Education Foundation
Attention: Janet McDowell
4107 N. Adrian Highway
Adrian, MI 49221

**FRANK & SHIRLEY DICK
HEALTH SCHOLARSHIP**

The Frank & Shirley Dick Scholarship is an annual scholarship which was established in 1997. The applicant must have graduated from a public or private Lenawee County high school and be pursuing a career in the health field.

APPLICATION

DATE: _____

Student's Full Name: Ms. _____
Mr. _____

Student's Address _____ Tel _____
Street Area/Number

Date & Place of Birth _____ City _____ State _____ Zip _____
Citizenship _____

Schools attended (ninth through twelfth grades) Attach Transcripts

| | | |
|----------------|------------------|-----------------|
| Name of School | Date of Entrance | Period Attended |
|----------------|------------------|-----------------|

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|----------------|------------------|-----------------|
| Name of School | Date of Entrance | Period Attended |
|----------------|------------------|-----------------|

| | | | |
|--------------------------------|-----------------|---------------|--|
| Date of high school graduation | Number in Class | Rank in Class | |
|--------------------------------|-----------------|---------------|--|

ACTIVITIES AND INVOLVEMENT

SCHOOL RELATED ACTIVITIES & INVOLVEMENT

Organization: Please state name of organization, year, and if an office was held.

For Example: Cheerleading 3,4 Co-Captain 4 Choir 2,3, American Studies Club 3 (treasurer). State only major activities.

Honors and Awards (state year and nature of honor or award). _____

NON-SCHOOL RELATED ACTIVITIES & INVOLVEMENT

Organization: Please state name of organization, year and if an office was held. For example: Church youth group, scouting, etc. State only major activities.

Honors and Awards (state year and nature of honor or award). _____

PLANS FOR COLLEGE

State your plans for enrollment in an accredited public or private post secondary institution. Please indicate the health field you wish to study.

EMPLOYMENT

Positions held in gainful employment, periods of employment, and average time employed each week, etc.

STATEMENT OF APPLICANT 

I understand that this Scholarship, if granted to me, is for pursuing a course of study in the field of health care. If for any reason my plans change, I will inform the Trustees by letter. At that time the Trustees will have the right to reevaluate my application and revoke my Scholarship.

I also understand that failure to notify the Trustees of any change in my college plans will result in automatic revocation of any Scholarship that I might have otherwise received from the Trust.

I understand that the LISD may publish my name and photograph if I am awarded this scholarship.

DATE: _____

Parent's Signature (If student is not 18)

Student Applicant Signature