

# 2026 Wright Memorial Hospital Auxiliary Scholarship Checklist

Applicant Name: \_\_\_\_\_

Please attach this checklist to the front of your application and ensure that all required materials are either sent with this application or postmarked by Wednesday, April 1, 2026. **Incomplete applications will not be considered.** It is the applicant's responsibility to ensure all documents have been submitted.

***Please check whether you are a:***

\_\_\_\_\_ **New Applicant** *(see section A below)*

\_\_\_\_\_ **Previous Recipient** *(see section B below)*

**A. New Applicant** *(and returning applicants who were not awarded a scholarship)*

\_\_\_\_\_ This checklist

\_\_\_\_\_ Completed application with essay

\_\_\_\_\_ Reference letter #1 \_\_\_\_\_ *(submitted with application or sent directly to WMH)*

\_\_\_\_\_ Reference letter #2 \_\_\_\_\_ *(submitted with application or sent directly to WMH)*  
Name  
Name

\_\_\_\_\_ **Letter on college/university letterhead confirming full & unconditional acceptance into a specific accredited 2-or 4-year college/university health care program.**

**B. Previous Recipient of WMH Auxiliary Scholarship**

\_\_\_\_\_ This checklist

\_\_\_\_\_ Completed application with essay

\_\_\_\_\_ College/University detailed transcript with classes taken & grades received

Application items may be sent as one packet or separately, but **this checklist must be completed by the student and accompany the application.** All applicants will be notified regarding the status of their application, and scholarship recipients will be invited to attend a brief ceremony (date to be determined) to receive their scholarship award.

Please contact Denise Hamilton at Wright Memorial Hospital with any questions about the scholarship, requirements, or eligibility at 660.358.5723.

*SLHS will not discriminate on the basis of race, color, sexual orientation, national origin, gender identity or expression, sex, age, religion or disability in admissions or access to, or treatment or employment in, or its programs and activities.*

# 2026 WMH AUXILIARY SCHOLARSHIP

Application Due: Wednesday, April 1, 2026

---

***Candidates permanent address must be in the 646XX zip code, and candidate must have been accepted into an accredited 2-or 4-year college or university health care program.***

**A copy of the letter of full and unconditional acceptance into a specific health care program from the college or university you are attending must be attached.**

I, \_\_\_\_\_ request consideration for a maximum \$1,000.00 of financial assistance from the WMH Scholarship Fund (\$500 each semester) to further my education in the field of health care. I understand I will need to reapply each year to be considered for a scholarship. I understand that I will be expected to share my grades and school status if I choose to apply for a scholarship renewal. I also understand that my eligibility for future scholarship awards is dependent upon completing my classes and receiving passing grades in each term for which I am awarded funds. If these conditions are not met, I understand I will not be eligible for further assistance for a period of one year.

---

Last Name	First Name	Middle Name	
Street	City/Town	State	Zip
_____	_____	Currently Employed? Y or N	
Cell Phone Number	Email address		
_____	_____	_____	
Current Employer?	How Long?	Approx. Gross Monthly Income	
_____	_____	_____	
Type of Training/Degree Seeking	Name of College Attending	Start Date	Proj. Grad. Date
_____	_____	_____	_____

Have you ever received and/or applied for the WMH Auxiliary Scholarship previously? Yes No

If so, what result did you receive and in what year:

Please list other financial assistance requested, and amount received:

Estimate of itemized costs for this semester:

**Please list your involvement with community, church or school activities.**

*(attach additional pages as needed)*

**In your own words, please tell us what experience you may have had in your chosen field. Why do you wish to be funded through the WMH Auxiliary Scholarship?**

*(attach additional pages as needed)*

All statements made in completion of the application are true and complete to the best of my knowledge. I give my permission to share any information contained herein with the Wright Memorial Hospital Auxiliary. I understand that if I am awarded a scholarship, my name and hometown will be shared in press releases and announcements.

Signed \_\_\_\_\_ Date \_\_\_\_\_

You must submit (2) two letters of recommendation from non-family members, (i.e. teacher, employer, minister, etc.) with your first application only. Send letters of recommendation and the completed application directly to:

Denise Hamilton  
Wright Memorial Hospital  
191 Iowa Boulevard  
Trenton, Missouri 64683

**Checklist, scholarship application, two letters of recommendation and copy of letter of acceptance must be received or postmarked by April 1, 2026.**