Wayne M. Henkle, MD Scholarship

Continuing Education or Skyline Department Training

Applications must delivered or post-marked to Skyline Foundation by April 30 for consideration. Send your application to Skyline Foundation, PO Box 1625, White Salmon, WA 98672, email it to HannahPrentice@skylinehospital.org or drop it off at Skyline Hospital.

Continuing Education

Applicants must meet the following criteria:

1. Must be a resident of the Skyline Hospital service area in Western Klickitat County or Skamania County or employee of Skyline Hospital. Employees are encouraged to apply.

2. Must have maintained a minimum GPA of 3.0 on a 4 point scale and/or supply a letter from your supervisor.

3. Must be seeking post-secondary education in the health care field.

4. Must be dedicated to returning to the Skyline service area to work or volunteer for a period of at least one year, if such employment or service is available.

5. Scholarship should be used within one year.

Payment will be made to the educational institution upon proof of enrollment.

Department Training
Innovative and specialized educational scholarship requests will be considered i.e. department training, advanced rescue, etc. Scholarships for in-service training will be evaluated individually on their merit and the criteria will be broad based.

The Foundation gives up to $3,000 of total scholarships per year (recipients receive $500-$1000) depending on the number of awards and requested amounts each year.

Skyline Foundation Scholarship Application
Wayne M. Henkle M.D. Scholarship

(Please type or print)

I. PERSONAL DATA

Full Name _____ Date of Birth _____

Mailing Address _____ City, State, Zip Code _____

Home Phone _____ Email _____

Employer_____ Occupation _____

Address _____ Full Time or Part-time _____

List names and ages of dependants _____

List your community, educational and organizational activities and note any honors or achievements:

_____

_____

Briefly state your career, academic and/or personal goals _____

_____

_____

Describe your work experience _____

_____

_____

If you know any employee of Skyline Hospital and or any member of Skyline Foundation, please provide their names and describe any relationship

_____

_____

II. EDUCATIONAL DATA

High School _____ City, State _____

Year Graduated _____ GPA _____ If GED date/place completed _____

Colleges/Universities Attended _____

_____

Number of Credits Earned to Date _____ Current GPA _____

College/School you will be attending _____

Term that the Scholarship is being applied for _____ Year _____

III. FINANCIAL INFORMATION

Have you received previous scholarships from Skyline Foundation? □ Yes □ No

If yes, specify amount and purpose _____

Have you applied for other scholarships or financial aid: □ Yes □ No

If yes, describe _____

_____

Is it necessary that you work in order to attend school? □Yes □ No

Briefly provide any additional financial, personal or professional information which may help us determine need or merit in making a scholarship available to you

_____

_____

Describe any skills that might be used in service to Skyline Hospital or other health care provider in our service area

_____

_____

Should a scholarship be awarded to you, would you be willing to commit a specified amount of time to Skyline Hospital at the conclusion of your education?

_____

_____

IV. EDUCATIONAL GOALS

COURSE #	SECTION #	COURSE TITLE	CREDITS

Briefly explain your reasons for taking the course(s)

_____

_____

_____

_____

_____

V. REFERENCES (Please attach letter(s) of recommendation from an appropriate agency or individual.)

Name _____ Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

The undersigned applicant hereby authorizes Skyline Foundation to contact parties named herein and to verify all information submitted.

I certify all statements and information furnished are true and complete.

Signed _____ Date _____