



Scholarship Information

The Clay Taylor Embry and Mary Almira Smith Embry Memorial Scholarship Fund is a continuing, fully-funded nursing scholarship to be administered by the TriState Health Auxiliary. It is funded through an endowment trust from the above individuals and was established in May, 1985.

Eligibility for the award is based on the following criteria:

- Applicant must be a high school graduate or the equivalent.
- Students must be enrolled in a full-time Health Science Program in the Fall term, -OR- applicant must be a full-time Health Science student entering the second year of the Health Science Program.
- Applicant must demonstrate a grade point average (GPA) of at least 2.5 in high school or equivalent course work, -OR- must have maintained an overall GPA of 2.5 with a minimum of 2.0 in any subject during first year of nursing program or other college level classes.
- Applicants may receive this scholarship twice.
- Applicant must be available for a face-to-face interview with Auxiliary Scholarship Committee.
- Applicant attending school in the Lewis-Clark Valley, Nez Perce County, or Asotin County preferred.
- Auxiliary Scholarships Funds are to be used for tuition, books, and labs. Funds are directly deposited to the attending college.
- Auxiliary Scholarship recipients must pledge to apply for a position at TriState Health upon graduation. If a position is available, and the applicant is hired for the position, they must commit to work at least one year after licensing. This requirement may be waived in lieu of missionary or public service commitments at the discretion of the Auxiliary Scholarship Committee.

To apply for the Embry Memorial Scholarship, please complete the attached application. **All scholarship application materials must include:**

- Application Form
- One Advisor/Counselor Report
- Two References(non-relatives)
- Official current grade transcript

Return completed application to the Human Resources Office at TriState Health by June 30. After June 30, the applications will be reviewed by the Auxiliary Scholarship Committee. Award recipients will be notified no later than August 1.

Campus Maps are located at TSH.org/contact-us/



Scholarship Application

Last Name _____ First Name _____ Middle Initial _____
 Address _____ City _____ State _____ Zip _____
 Graduating High School _____ City _____ State _____ Zip _____
 Year of Graduation _____

**TO ALL APPLICANTS: PRIOR TO COMPLETING THIS APPLICATION,
PLEASE READ ALL ENCLOSED MATERIALS.**

For scholarship consideration, you must submit this completed application form, your Official Current Grade Transcript showing a cumulative grade point average on a 4.0 scale, two reference reports, and an additional report from the principal/dean or college counselor at your graduating high school or college.

All scholarship application materials must include:

- Application Form
- One Principal/Counselor Report
- Two References (non-relative)
- Official current grade transcript

Must be received by the Auxiliary, at TriState Health, no later than June 30.

ALL materials MUST be mailed or delivered in a single package to:

TriState Health
 ATTN: Human Resources,
 PO Box 189
 Clarkston, WA 99403
 509.758.5511

June 30 is the final date for receipt of applications.

FOR OFFICE USE ONLY

Number _____ Auxilian _____



Scholarship Application Continued

Applicant's Name _____

Phone # _____ Email _____

Date of Birth _____ Social Security Number (Last 4-digits) _____

PARENT INFORMATION - DO NOT COMPLETE IF YOU ARE MARRIED OR OVER AGE 21

	Father	Mother
Name		
Address		
Occupation		
Employer		

FAMILY INFORMATION

Total Number of Siblings _____ Siblings Living at Home _____

Other Dependents Who Live With Your Parents _____ Please Specify _____

Your Marital Status _____ Number of Children _____

SPOUSE INFORMATION

Name _____ Occupation _____

Employer _____

EMPLOYMENT HISTORY

Job Title	Employer	Hours Worked Per Week	Length of Employment

Are you currently employed? Yes No Do you plan to work next fall? Yes No

Do you contribute to household expenses? Yes No If yes, what percentage? _____

ACHIEVEMENTS & ACTIVITIES

Please list achievements, Honors, and Recognitions (High School/College) _____

Please list extracurricular activities _____



Scholarship Application Continued

COLLEGE INFORMATION

What is the college you plan to attend next fall? _____

Enrollment Date _____ Field of Study _____ Degree Sought _____

Program Enrolled in 2-year 4-year Other (specify) _____

Anticipated College Graduation Date _____

INCOME INFORMATION

Please estimate your parents' (father and mother, if both work and you are under 21 years of age) and your total gross income for the last calendar year. If married, please include your spouse's income.

Parents' Estimated Income <\$5,000 \$5,000-\$10,000 \$10,001-\$20,000 \$20,001-\$30,000
 \$30,001-\$40,000 \$40,001-\$50,000 \$50,000+

Self/Spouse Income <\$5,000 \$5,000-\$10,000 \$10,001-\$20,000 \$20,001-\$30,000
 \$30,001-\$40,000 \$40,001-\$50,000 \$50,000+

To the best of your knowledge, please indicate by source and by percentage, the actual funds you have available for college expenses, Self/Spouse _____ Parents _____ Other Scholarship _____
Other _____ Please specify other source _____

NOTE: A 100% total would indicate that all college expenses are covered. Your total may be less than that amount.

OTHER SCHOLARSHIPS FOR WHICH YOU HAVE APPLIED _____

TRISTATE HEALTH EMPLOYMENT

If any of your immediate family presently works or has worked for TriState Health, please provide the information below.

	Name	Current or Former Employee	Position Held
Father			
Mother			
Sibling(s)			
Grandparent(s)			



Scholarship Application Continued

Please answer the following questions as completely as possible. If more room is needed to answer any of the questions, attach extra sheets of paper, labeled with your name and the question number.

1. Why did you choose nursing as a career? _____

2. Briefly describe why you feel you should be a scholarship recipient? _____

3. What are your career plans? How does TriState Health fit into your plans? _____

4. What are your other goals? _____

Please list the two people you asked to complete Confidential References (non-relatives).

Name _____ Address _____ City _____ State ____ Zip _____

Name _____ Address _____ City _____ State ____ Zip _____

Please list the counselor you asked to complete the Confidential References (advisor or counselor).

Name _____ Address _____ City _____ State ____ Zip _____

To the best of my knowledge, the foregoing statements are accurate.

Signature _____

Date ____/____/____



**AUXILIARY NURSING & HEALTH SERVICES
SCHOLARSHIP PROGRAM
CONFIDENTIAL REFERENCE REPORT -
ADVISOR OR COUNSELOR**

The applicant listed below is applying for a college scholarship from our Auxiliary. Your assistance in determining the worthiness of this applicant will be appreciated by our Scholarship committee-and will be kept confidential. Your cooperation is requested in returning this form to the applicant as soon as possible. In order for this applicant to be considered for a scholarship, **this report must be included in the application, which must be received no later than June 30.**

Applicant to complete this information.

Applicant's Name _____

Phone # _____ Email _____

Date of Birth _____ Social Security Number (Last 4-digits) _____

Year of High School Graduation _____ High School Attended/Attending _____

The following information is to be completed by the principal/counselor at the applicant's current or recently attended school and returned directly to the applicant in the sealed confidential envelope.

Applicant's Current Cumulative GPA (on a 4.0 scale) _____

What honors have been received by this applicant? _____

Please write below your opinion and observations concerning this applicant's strongest assets and greatest weaknesses or difficulties in being a successful college student. Also include your evaluation of the applicant's compatibility with instructors and peers.

What is your estimate of the applicant's ability and motivation in accomplishing college work?

- Superior Above Average Average May have some difficulty and should have special guidance and attention

Any additional comments _____

Signature _____ Date ____/____/____

School Full Name _____ School Phone # _____

School Address _____ City _____ State ____ Zip _____

PLEASE ENCLOSE THIS IN AN ENVELOPE MARKED "CONFIDENTIAL," SEAL IT, AND RETURN IT TO THE APPLICANT.

Applicant return to: TriState Health
ATTN: Human Resources,
PO Box 189
Clarkston, WA 99403
509.758.5511



**AUXILIARY NURSING & HEALTH SERVICES
SCHOLARSHIP PROGRAM
CONFIDENTIAL REFERENCE REPORT -
PERSONAL (NON-RELATIVE)**

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Applicant to complete this information.

Applicant's Name _____
 Phone # _____ Email _____
 Date of Birth _____ Social Security Number (Last 4-digits) _____
 Year of High School Graduation _____ High School Attended/Attending _____

The following information is to be completed by the personal reference and returned directly to the applicant in the sealed confidential envelope.

What is your association with the applicant (Teacher, Employer, Neighbor, etc.)? _____
 How long have you known the applicant? _____

In your opinion, is the applicant fully qualified as to character, personality, leadership qualities and scholastic achievement to merit consideration of an award of this kind? Yes No

Please explain _____

What is your estimate of the applicant's ability and motivation in accomplishing college work?

Superior Above Average Average May have some difficulty and should have special guidance and attention

In your opinion, does the applicant need financial aid to attend college? Yes No

Please explain _____

Any additional comments _____

Signature _____ Date ____/____/_____
 Phone # _____ Address _____ City _____ State ____ Zip _____

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 PO Box 189
 Clarkston, WA 99403
 509.758.5511 ext. 4304



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SCHOLARSHIP PROGRAM
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Clarkston, WA 99403
509.758.551