



STANDARD EDUCATIONAL SCHOLARSHIP PROGRAM

Available Scholarship Specialty Programs:

LPN	Nuclear Medicine Tech
Occupational Therapy	Pharmacy
Physical Therapy	Physical Therapy Assistant
Radiologic Tech	Registered Nurse
Respiratory Therapy	

- I. To qualify as a candidate for financial assistance, the student must:
 - A. Be enrolled in the program of specialty identified above.
 - B. Apply for funding by providing:
 1. Completed application documents and mailing to:
Peninsula Regional Medical Center
Attn: Jennifer Roglitz - Department of Education
100 E. Carroll Street
Salisbury, MD 21801
 2. Three letters of reference from educators, community members, or others who have had an association with you. (Reference letters must come directly to Peninsula Regional from the originator.)
 3. Three Employee Reference Inquiries from your three most recent places of employment. (This can be from more than one supervisor at the same employment location, a volunteer position, etc.)
 4. Official transcripts from high school and/or any post-secondary schools attended
 5. Verification of acceptance in the program of specialty identified above
 6. An essay on why you have chosen to pursue your specialty program
 - C. Be interviewed by Peninsula Regional Medical Center representatives.
 - D. Agree to work full-time in a clinical position at Peninsula Regional Medical Center for a pre-determined amount of time based on financial assistance. Payback time to be stipulated in contract.
- II. Scholarships will be awarded based on criteria identified in I. A-D above.
- III. Scholarship funds are available to offset expenses for tuition, books, fees and supplies and can be paid directly to the school or to the scholarship recipient after presenting valid receipts.
- IV. Students must maintain a minimum grade point average of 2.0 and be in good standing with the Program in order to continue receiving financial support.
 - A. Student will provide official grades for copying to Peninsula Regional Medical Center at the end of each marking period.
 - B. A student who does not maintain academic standards shall be required to pay back sums advanced.
- V. Students who drop out of the program will be required to repay sums advanced.
- VI. Students who complete program and elect to work at another facility before satisfying their commitment to Peninsula Regional Medical Center will be expected to repay the scholarship loan.
- VII. Contact Jennifer Roglitz at 410-543-7126 if you need additional information.



PENINSULA REGIONAL MEDICAL CENTER
APPLICATION FOR STANDARD EDUCATIONAL SCHOLARSHIP ASSISTANCE

Date: _____

Name: _____ SS #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone #: _____

Cell Telephone #: _____

Email: _____

Name of School (Attending or Entering): _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Secondary And/Or Other Post Secondary School(s) Attended: _____

Address: _____

City: _____ State: _____ Zip: _____

Address: _____

City: _____ State: _____ Zip: _____

Scholarship Program for Which You Are Seeking Assistance:

LPN _____	Nuclear Medicine Tech _____
Occupational Therapy _____	Pharmacy _____
Physical Therapy _____	Rad Tech _____
Registered Nurse _____	Respiratory Therapy _____
Speech Therapy _____	Surgical Tech _____

Expected Graduation Date: _____

Please provide information about any other scholarship assistance you are/will be receiving.

Are you currently employed by Peninsula Regional Medical Center?
Yes _____; Area and Ext. _____ No _____

Have you previously been employed by Peninsula Regional Medical Center?
Yes _____ No _____

IMPORTANT: ATTACH A COPY OF YOUR ACCEPTANCE LETTER INTO YOUR SPECIALTY PROGRAM.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize **Peninsula Regional Medical Center** (hereafter "the Company" or "Employer"), its employees, agents, private investigators or any representative of the aforesaid company, to perform investigations into my background, past behavior, to my character, general reputation, and mode of living including but not limited to:

Investigative Consumer Reports: I authorize the Company to perform investigative consumer reports that may include credit reports, criminal history or arrest records, workers' compensation histories, motor vehicle records, employment and unemployment records, military records, or other sources of information.

Education and Employment: I authorize schools, colleges and all scholastic institutions to release any and all information requested. This includes transcripts, grades, attendance records, and any other information requested. I authorize all former and current employers to release any and all information regarding my employment history. This includes all information contained in my personnel file, salary history, condemnations, and all other pertinent information. I further authorize my supervisors and other work associates to disclose their opinions and observations of my work habits, qualities, competency, and skills. Furthermore, I authorize full disclosure of any and all drug and alcohol testing results.

Authorization and Understanding: I authorize custodians of the records of any agency, government agency, or company as described above to release such information upon request of any investigator, agent, or representative of the Company. I understand that any or all of these investigations or inquiries can be performed prior to and periodically throughout the duration of my employment. I understand that the information requested is for the use by the Company and may be re-disclosed only as authorized by law. I understand that I have the right to request from the Company a written disclosure of the nature and scope of the investigation conducted that I authorized above. If you are a Minnesota, California or Oklahoma resident only and you want a copy of your report, check here ____. The reports will be mailed to you at the address below. I indemnify, release, and hold harmless the Company, any agents of the Company, or others reporting to or for the Company, any investigators, all former employers, reporting agencies, and all those supplying references and character references, from any and all claims, defamation, demands, and/or liabilities arising out of, or related to, such investigations, disclosures, or admissions. Copies and facsimile transmissions of this authorization that show my signature are as valid as the original release signed by me.

TO BE COMPLETED BY APPLICANT

The Following Information Is True And Correct To The Best Of My Knowledge And Is Used For Identification And Investigative Purposes Only.
Please Use an Ink Pen and Print Clearly. Use "UPPER CASE" Letters. One Letter Per Block.

Last Name																	
First Name																	
Middle Name																	
Current Address														Apt.#			
City											State			Zip			
Social Security Number																	
Date of Birth																	
Driver's License No.											State						
Other Last Names Used																	
Other States and Counties I Have Lived		STATE	COUNTY	ZIP CODE	FROM (YR)	TO (YR)		STATE	COUNTY	ZIP CODE	FROM (YR)	TO (YR)					
	1						3										
	2						4										
Applicant Signature:							Date:										

To Be Completed By: Peninsula Regional Medical Center <input checked="" type="checkbox"/> Criminal Records (see notes) County: _____ State: _____ County: _____ State: _____ County: _____ State: _____ County: _____ State: _____ <input type="checkbox"/> Federal Criminal Records County: _____ State: _____ County: _____ State: _____ County: _____ State: _____ <input type="checkbox"/> CHIPS! <input checked="" type="checkbox"/> Social Security Number Trace <input type="checkbox"/> Residential PLUS! <input type="checkbox"/> Credit Report Client Signature: _____	Reference: <input type="checkbox"/> Motor Vehicle Record <input type="checkbox"/> Workers' Compensation History State: _____ State: _____ State: _____ State: _____ <input type="checkbox"/> Employment Verifications (Application Required) <input type="checkbox"/> Do not verify current employer <input type="checkbox"/> Professional License Verification: _____ <input type="checkbox"/> Educational Verifications (Application Required) <input type="checkbox"/> National Wants and Warrants <input type="checkbox"/> Sex Offenders Registry <input type="checkbox"/> Prison Inmate Search <input type="checkbox"/> Other/Special Instructions: _____ Date: _____
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Date: _____

TO: Department of Education

REF: Credentialing Authorization for Consideration of Scholarship Loan

I am applying for a Peninsula Regional Medical Center (PRMC) Scholarship Loan to assist with the cost of my education. I hereby authorize PRMC to complete a credentialing check to assist with determining my eligibility.

I understand that my credit score and/or credit report will be verified, and that a poor credit score may affect my acceptance into the program.

Applicant's Full Name:

Please Print

Social Security Number:

Applicant's Signature:

Please Sign



***Scholarship Applicant Drug and Alcohol Testing
Authorization and Release***

I hereby consent for any necessary specimens of urine to be taken and tested by a laboratory designated by Peninsula Regional Medical Center to determine the presence or absence of drugs in my system. I hereby authorize the Medical Center to take specimens and to perform any tests to make this determination. I agree to cooperate in the taking and testing of such specimens. I also authorize the release of the results of such test to Employee Health and a Medical Review Officer who is responsible for reviewing and verifying test results. I also authorize the release of the verified tests result from the Medical Review Officer to Medical Center management officials and any board, licensing agency, contractual or temporary agency, or school program that I am affiliated with or as required by law.

I understand that the results of the test will be used to determine my eligibility for participation in the Medical Center Scholarship Loan Program. I understand that refusal to consent or cooperate in giving any necessary urine specimens in anyway and/or avoiding/hindering of the testing process as required will result in my ineligibility for participation in the Medical Center Scholarship Loan Program. If my specimen is cold and less than 90 degrees Fahrenheit, I understand that I may be asked to participate in an observed urine collection and/or possibly withdraw from scholarship loan program consideration. I understand that a positive test result will result in my ineligibility for scholarship loan program consideration with the Medical Center for a period of 12 months.

I understand and consent for the Medical Review Officer and/or Employee Health Nurse to contact myself or physician, pharmacist or other appropriate medical care provider for verification of prescription and the medical condition requiring the prescription medication. Confirmation of a controlled substance that is not properly verified will result in a positive specimen.

I hereby release the Medical Center, the laboratory performing the testing/analysis, the Medical Review Officer reviewing and verifying the test results, and all of their officers, directors, employees, attorneys, representatives, and/or agents from any and all liability and damages arising out of taking or testing of any specimens of my urine and communicating the test results pursuant to this authorization and release.

I understand a documented chain of specimen custody exists to ensure the identity and integrity of my specimens throughout this collection and testing process.

I have been advised that I have the right to request independent testing (at my own expense) of the specimens.

I understand that this testing authorization and release does not constitute an employee agreement or contract with the Medical Center. I have signed this authorization and release voluntarily and of my own free will.

Date

Signature

Social Security Number

Applicant Name (Print)

Date

Witness



PRESCRIPTION AND NONPRESCRIPTION DRUG INFORMATION

Name: _____ S.S.#: _____

Date of Birth: _____

If any prescribed medications are found in your lab results, you must produce a prescription from your physician.

Please list all drugs/medications that you are currently using. These should include both over-the-counter and prescription medications.

Name of Medication	Date Prescribed	Dosage & Frequency	Physician
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Scholarship Candidate's Signature: _____

Date: _____

Witness: _____

Date: _____



EMPLOYEE REFERENCE INQUIRY

Peninsula Regional Medical Center

Department of Education

100 East Carroll Street

Salisbury, Maryland 21801

HUMAN RESOURCES

Phone: 410-543-7126 Fax 410-543-4726

Top Portion to be Completed by Applicant (Do Not Detach)

Submit along with Scholarship Application

FORMER EMPLOYER: _____

• SUPERVISOR : _____

• CONTACT NUMBER: _____

NAME: (at time of employment): _____

POSITION HELD: _____

SOCIAL SECURITY NO: _____ BIRTHDATE: _____

EMPLOYED FROM: _____ TO _____

I HEREBY AUTHORIZE ALL CURRENT OR FORMER EMPLOYERS TO FURNISH PENINSULA REGIONAL MEDICAL CENTER IN SALISBURY, MARYLAND, WITH ANY INFORMATION CONCERNING MY EMPLOYMENT HISTORY WHICH THEY HAVE ON RECORD AND HEREBY RELEASE THESE FORMER EMPLOYERS AND ALL INDIVIDUALS ASSOCIATED WITH THEM FROM LIABILITY FOR ANY DAMAGES INCURRED IN FURNISHING SUCH INFORMATION.

SIGNATURE: _____ DATE: _____

PLEASE COMPLETE THE FOLLOWING EVALUATION CONCERNING THE PERSON WHOSE NAME APPEARS ABOVE. YOUR RESPONSE WILL BE KEPT IN STRICT CONFIDENCE. THANK YOU!

To Be Completed by Employer:

JOB TITLE: _____ EMPLOYED FROM: _____ TO _____

REASON FOR LEAVING _____

	Excellent	Above Average	Satisfactory	Marginal	Poor
WORK QUALITY					
WORK QUANTITY					
JUDGEMENT					
ORGANIZATIONAL ABILITY					
COOPERATION/ATTITUDE					
ATTENDANCE/PUNCTUALITY					

WOULD YOU REHIRE? YES _____ NO _____ IF NOT, WHY? _____

COMMENTS: _____

DATE: _____ SIGNATURE: _____ TITLE _____



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POSITION HELD: _____

SOCIAL SECURITY NO: _____ BIRTHDATE: _____

EMPLOYED FROM: _____ TO _____

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To Be Completed by Employer:

JOB TITLE: _____ EMPLOYED FROM: _____ TO _____

REASON FOR LEAVING _____

	Excellent	Above Average	Satisfactory	Marginal	Poor
WORK QUALITY					
WORK QUANTITY					
JUDGEMENT					
ORGANIZATIONAL ABILITY					
COOPERATION/ATTITUDE					
ATTENDANCE/PUNCTUALITY					

WOULD YOU REHIRE? YES _____ NO _____ IF NOT, WHY? _____

COMMENTS: _____

DATE: _____ SIGNATURE: _____ TITLE _____



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JOB TITLE: _____ EMPLOYED FROM: _____ TO _____

REASON FOR LEAVING _____

	Excellent	Above Average	Satisfactory	Marginal	Poor
WORK QUALITY					
WORK QUANTITY					
JUDGEMENT					
ORGANIZATIONAL ABILITY					
COOPERATION/ATTITUDE					
ATTENDANCE/PUNCTUALITY					

WOULD YOU REHIRE? YES _____ NO _____ IF NOT, WHY? _____

COMMENTS: _____

DATE: _____ SIGNATURE: _____ TITLE _____