



STRATHMORE DISTRICT HOSPITAL AUXILIARY
BURSARY APPLICATION INFORMATION

NAME: _____

Surname: _____ Given Name: _____

ADDRESS: _____

PHONE NUMBER: _____

NAME AND LOCATION OF HIGH SCHOOL LAST ATTENDED:

YEAR OF GRADUATION FROM HIGH SCHOOL: _____

CHOSEN MEDICAL FIELD: _____

ORIGINAL START DATE OF COURSE: _____

COURSE LENGTH (Number of years): _____

YEARS CURRENTLY COMPLETED: _____

NAME OF UNIVERSITY, COLLEGE OR PLACE OF LEARNING:

ADDRESS OF PLACE OF LEARNING: _____

REASON FOR CHOOSING THIS COURSE: _____

LETTERS OF REFERENCE: **Two (2) letters of reference** must be enclosed from individuals other than family members or fellow students.

Name: _____ Phone: _____

Name: _____ Phone: _____

CRITERIA FOR AWARDING THE BURSARY

NUMBER OF BURSARIES AVAILABLE: _____

BURSARY AMOUNT: _____

Candidates must be entering or presently enrolled in **post-secondary studies** in a Health-Related training program.

1. Candidates **must** be from the County of Wheatland.
2. Candidates may be enrolled in any recognized, accredited post-secondary institution.
3. The application form must be accompanied by a letter of not less than 250 words or more than 500 words. It should focus on your reasons for financial need and outlines how the chosen course supports your academic or career objectives.
4. An **official transcript** of the applicant's marks for High School (grades 10, 11 and 12) must be provided.
5. Applicants will be notified of competition results by September 30.
6. Selection will be based equally on financial need, academic achievement, and community involvement.
7. Applicants should expect to be interviewed.
8. The Strathmore District Hospital Auxiliary will promote the award through social media as well as through the local paper and radio station.

9. The completed application form and the official transcript should be mailed to:

Strathmore District Hospital Auxiliary
Attn: Committee Chair
847 Bayview Cres.
Strathmore, AB T1P 1E2

Email to: strathmorehospitalfoundation@gmail.com

FINANCIAL INFORMATION

MARITAL STATUS OF APPLICANT: _____

SPOUSES OCCUPATION (If applicable): _____

ESTIMATED EARNINGS FROM SUMMER EMPLOYMENT: _____

ESTIMATED EARNINGS DURING SCHOOL YEAR: _____

IF YOU ARE UNABLE TO WORK FULL TIME DURING THE SUMMER GIVE THE REASON WHY: _____

ASSETS:

Vehicle value _____ Monthly Payments _____

House value _____ Monthly Payments _____

COMPLETE THIS BUDGET FOR THE FOLLOWING ACADEMIC YEAR:

INCOME

Savings as of September 1 st :	\$
Investments:	\$
Expected part-time earnings during the academic year:	\$
Scholarships/Bursaries (confirmed for the upcoming year):	\$
Contribution from parents:	\$
Contribution from spouse:	\$
Net earnings during the academic year:	\$
Other Income:	\$
TOTAL INCOME	\$

EXPENSES

Tuition and Fees	\$
Books and Supplies	\$
Where do you plan to live while taking your course?	
Estimated living costs (food, rent, transportation, utilities & personal expenses) \$ per month _____ x months _____ = total	\$
Childcare: \$ per month _____ x months _____ = total	
Other expenses: specify	\$
TOTAL EXPENSES	\$

TOTAL INCOME – TOTAL EXPENSE = SURPLUS OR SHORTFALL	\$
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COMMITTEE APPROVAL

1. The applicant must be actively engaged in the course for which the award is made.
2. The applicant must be intent on completing the program of studies stated in their application.
3. The winning applicant (s) must agree to and submit their picture for the publicizing of the award.
4. The application must be signed.

I hereby certify that the information given on this application is complete and true in all respects. If I receive a bursary award, I authorize the Strathmore District Hospital Auxiliary to release my name and details of the award to the public.

DATE: _____ SIGNATURE: _____

DEADLINE FOR SUBMITTING APPLICATION

JULY 15, 2026