



**Alliance for Rural Community Health  
Diversity in the Workforce  
Empowerment through Education**

**Health Professions Scholarship Program**

**RENEWAL APPLICATION**

*Completing the Renewal Application indicates you have submitted a full Application in the past, received a scholarship award, and are now applying for additional monies. If it has been more than one year since your last application, you must submit a full Application. Contact Nancy Eachus at 462-1477 x102 for a full Application.*

Name \_\_\_\_\_ Email Address \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_

Date of most recent ETE award \_\_\_\_\_ Amount awarded \_\_\_\_\_

Are you currently enrolled in a health professions educational program?  Yes  No

What is your program/goal? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Program Location: \_\_\_\_\_  
School City

Date program began \_\_\_\_\_ Length of program \_\_\_\_\_

Expected Date of Completion \_\_\_\_\_

Have your goals and/or plans changed since your original application was submitted?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

**If you are currently employed, please complete:**

Employer \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip

Position Held \_\_\_\_\_ Office Phone \_\_\_\_\_

Employment Start Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Employment End Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Average hours worked per \_\_\_\_\_ Monthly Salary \$ \_\_\_\_\_

Brief description of your job duties \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Mail Renewal Application to:**

Alliance for Rural Community Health  
Attn.: Nancy Eachus  
367 N. State St., Suite 201  
Ukiah, CA 95482

**CHECKLIST FOR SUBMISSION**

- Completed Application
- Course Enrollment Verification Form
- Expense & Assistance Record
- Transcripts w/grades for the period time for which you were previously funded

**APPLICATION CERTIFICATION**

I certify that all information in this application is true and accurate to the best of my knowledge. I authorize the Alliance for Rural Community Health to verify any information submitted as part of this application. I understand that falsification of information contained in this application will disqualify my application.

I understand that if falsification is discovered after I have been awarded, I will be required to repay all funds awarded, plus interest and administrative fees.

I understand that once I have submitted my application and supporting documents, they become the rights of the Alliance for Rural Community Health. I authorize ARCH to use my name as a recipient of an ETE scholarship in press releases. I also understand that my personal statements in Part C become the property of ARCH and may be used, including but not limited to, advertising/marketing programs, reports, newsletters, and other publications. Confidentiality will be maintained when quoting from Part C.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

*The Empowerment Through Education - Minority Scholarship Program is funded by a grant from The California Wellness Foundation (TCWF). Created in 1992 as an independent, private foundation, TCWF's mission is to improve the health of the people of California by making grants for health promotion, wellness education, and disease prevention programs.*

**EDUCATION EXPENSES  
&  
FINANCIAL ASSISTANCE RECEIVED**

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

Did you receive a previous award? Yes \_\_\_ No \_\_\_ What amount? \_\_\_\_\_ Date Received \_\_\_\_\_

**PLEASE LIST YOUR EXPENSES FOR THE CLASSES (SEMESTER) YOU ARE APPLYING FOR:**

**What did you spend on the following?**

Were your fees waived? Yes \_\_\_\_\_ No \_\_\_\_\_

Tuition paid \$ \_\_\_\_\_

Health/Student fees \$ \_\_\_\_\_

Books \$ \_\_\_\_\_

Materials \$ \_\_\_\_\_

Childcare \$ \_\_\_\_\_

Other \$ \_\_\_\_\_ Explain \_\_\_\_\_

Gas \_\_\_\_\_  
Estimate your total miles

**PLEASE LIST ANY ASSISTANCE YOU WILL BE RECEIVING FROM OTHERS:**

Pell Grant \$ \_\_\_\_\_

Financial Aid \$ \_\_\_\_\_

Assistance from your employment \$ \_\_\_\_\_

Scholarship \$ \_\_\_\_\_

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This Section Completed by Alliance for Rural Community Health

Total Expenses \$ \_\_\_\_\_

Assistance Received \$ \_\_\_\_\_

**Financial Need** \$ \_\_\_\_\_

## Course Enrollment Verification Form

(TO BE COMPLETED BY SCHOOL PERSONNEL WHERE APPLICANT IS CURRENTLY ENROLLED)

*The student named below is applying for a health professions scholarship from the Alliance for Rural Community Health. This form is required for the application to be considered.*

Applicant's Name \_\_\_\_\_

Please describe the applicant's program of study: \_\_\_\_\_

\_\_\_\_\_

School \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date Entered \_\_\_\_\_ Expected Graduation/Completion Date \_\_\_\_\_  
*month/year month/year*

Enrollment Status:  full-time  part-time # of units currently enrolled \_\_\_\_\_

OR  enrolling (semester / date) \_\_\_\_\_

Please comment on the student's performance and potential for academic success.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### FORM COMPLETED BY:

Name (please print) \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

**Please Check:**  I certify that I am authorized to sign this document on behalf of the school.

**Please fax to 707-462-1503 when completed and signed.  
If you have any questions, contact Nancy Eachus at (707) 462-1477, ext. 102.  
This form is confirming registration for a scholarship application  
to the Alliance for Rural Community Health.**