DOCTORS
MEDICAL CENTER

Dear Prospective Scholarship Recipient,

Thank you for your interest in the Carol Welsh Memorial Scholarship Fund.

The Volunteer Service League at Doctors Medical Center is proud to offer this annual scholarship to assist students pursuing a career in medicine or a health-related field. Up to seven $1000 scholarships will be provided in 2010. The purpose of the scholarships is to help students with tuition. The Carol Welsh Memorial Scholarship Fund is supported by donations to the DMC Volunteer Service League.

Applications are due no later than March 1, 2010 to the following address:

Doctors Medical Center Service League
Attn: Scholarships Administrator
2000 Vale Road
San Pablo, CA 94806

Late or incomplete applications will NOT be accepted.

The following criteria will be used to evaluate applications:

Criteria	Points
• Quality of Reference	2 points
• Application and Person Statement	3 points
• Hospital or Healthcare Work Experience	3 points
(If volunteer or employee at DMC)	1 point
• In-person Interview / Oral	4 points
• Financial Need	4 points
TOTAL	17 points

An in person interview with the Scholarship Committee will be scheduled with all final candidates. Scholarship checks will be issued directly to the scholarship recipient's college/university in August 2010.

The Scholarship Committee looks forward to receiving your application. If you have questions or need additional information, please contact the DMC Service League at (510) 970-5334.

Sincerely,
Scholarship Chairperson
DMC Service League

CAROL WELSH MEMORIAL SCHOLARSHIP FUND
SUPPORTING INFORMATION

Each applicant should submit a complete application packet to the Carol Welsh Memorial Scholarship Committee, DMC Service League. The following items must be included in the in the application packet to be considered (check box if included in packet):

- ☐ Complete and signed scholarship application.
- ☐ Complete and signed Supporting Information sheet (this document).
- ☐ Official school transcripts showing a Grade Point Average of 3.5 or higher.
- ☐ Personal statement (500 word essay style) with a focus on applicant's life experience, future goals and financial need.
- ☐ Letter of recommendation from an instructor, academic counselor or a member of the medical field (on official letterhead stationary). Please note that notes and/or comments will not be accepted.
- ☐ Resume that includes activities and membership(s) in college and/or community clubs, activities or organizations.

The above information must be submitted by March 1, 2010. Late or incomplete applications will not be accepted.

To be eligible for the Carol Welsh Memorial Scholarship, the applicant must confirm the following (check box to confirm):

- ☐ I will be starting a 2-year nursing program, or
- ☐ I am entering the 2nd, 3rd or 4th year of an accredited college or university
- ☐ I have a permanent residence in West Contra Costa County

Furthermore, I agree that to the following (check box to confirm):

- ☐ I understand that it is my responsibility to advise the Scholarship Committee of the name and address of the College I will be attending.
- ☐ The scholarship check will be mailed directly to the college or university to be used towards school tuition.
- ☐ I will keep the Scholarship Committee informed, in writing, of my progress in my academic studies.

I ATTEST TO THE TRUTH OF THE ABOVE INFORMATION

Applicant's Signature ______________________________ Date: _______________

CAROL WELSH MEMORIAL SCHOLARSHIP FUND

SCHOLARSHIP APPLICATION

(Please type or print clearly)

Last Name:	First Name:	Middle Initial:
Permanent Home Mailing Address:		
City:	State:	Zip:
Telephone Number:		
Cell Phone Number:		
Name of College or University:		
Current cumulative grade point average:		As of (date):

List scholastic, extra curricular activities, honors, awards, offices held, leadership experience, and volunteer activities (Use additional sheet(s) of paper if necessary):

1.
2.
3.
4.
5.

Employment History, including length of employment and contact information (Use additional sheet(s) of paper if necessary):

1.
2.
3.

What is your current objective for a health care related profession? (Use additional sheet(s) of paper if necessary):

____

____

List all schools to which you have applied to attend in the Fall of 2010:

School Name & Location	Major	Accepted (y/n)
1.		
2.		
3.		
4.		
5.		

I ATTEST TO THE TRUTH OF THE INFORMATION IN THIS APPLICATION.

Signature:____Date:___________________

Authorization and Consent to
Photograph, Record, Interview and/or Publish Information, Statements or Images

I consent to Doctors Medical Center San Pablo (the Hospital), the West Contra Costa Healthcare District (the District), or affiliated group, or other persons permitted by the aforementioned to photograph, record, conduct media interviews and/or publish information, statements or images regarding *(Name of Patient/Individual)* ___________________________ obtained while under the care of the Hospital, and/or while visiting the Hospital, and/or while working at the Hospital.

I agree that the photographs, and/or radio, and/or television broadcast tape, and/or other recordings, and/or personal testimonial may be used in publications, websites, or other formats as deemed appropriate. I understand and agree that the photographs, recording and/or publication may reveal the patient's identity and that their use is subject only to the following restrictions:

____

I consent to the publication of information, statements or images of or about me in order to assist scientific treatment, educational, promotional, public relations and charitable goals. By signing this authorization and consent form, I hereby waive any right to compensation for such uses, and I and my successors or assigns hereby hold the hospital, its administrators, directors, officers, employees or agents and related entities, and the attending physician and their successors and assigns harmless from and against any claim for any injury, and any compensation, resulting from the activities authorized by me in this consent form.

I hereby waive my right under relevant state laws to patient confidentiality with respect to the taking or publishing of any photograph, record, interview, statement or image of me, as authorized in this consent form, with the exception of those limitations specifically identified by me in this consent form. I understand that I have the right to revoke this waiver, and to revoke my consent and authorization in this form, at any time, by notifying the hospital in writing, as discussed herein. **This consent form must be updated if patient condition changes and/or if new information, photographs, recordings or interviews are conducted.**

By signing below, I acknowledge that I have read and understand the above and agree to the terms of this consent.

Signature of Patient/Individual or
Legally Authorized Representative: ___________________________ Date: ________, 2010 Hour: ______am/pm

If Individual/Patient is unable to sign this Authorization (or if under the age of 18), please complete the information below:

Name of Legal Guardian/ Personal Representative: ___________________________ Legal Relationship: ______________ Date: ___________, 2010

DOCTORS
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You have the right to receive a signed copy of this authorization.