



MGHF Auxiliary
PO BOX 1668
Shelton, WA 98584
(360) 426-8433

For: [NEW] Mason County High School Applicant

Re: Mason General Hospital Foundation Auxiliary Scholarship Program

Dear Applicant:

For more than 50 years, the Mason General Hospital Foundation Auxiliary has been offering scholarships to high school seniors, adults and Mason Health employees interested in entering the healthcare field. At first, the scholarship was only available to nurses. When more scholarship funding became available, the Auxiliary began to expand the program to provide financial support for education of other positions.

The number and amount of each scholarship is determined annually from the MGHF Auxiliary Gift Shop profits, memorial gifts, and other donations.

You may attach additional documentation that is relevant to your application and submit them together.

If you have questions about the Scholarship application process, you can contact Carol Goodburn, Auxiliary Treasurer, at (360) 426-8433.

Please return completed applications to: High School Counselor's Office

All applications must be postmarked or received by April 19, 2024.

Thank You!





**MASON GENERAL HOSPITAL FOUNDATION AUXILIARY
HIGH SCHOOL SCHOLARSHIP APPLICATION
(Medically Related Fields)**

Application Deadline: April 19, 2024

MGHF Auxiliary – Graduating High School Senior

Full Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (City, State) (Zip Code)

Phone Number(s): _____

E-Mail Address: _____

High School Attended: _____

GPA: _____ Graduation Date: _____

College/University planning to attend: _____

Area of Interest or Major: _____

High School and/or Community Activities: _____

Work Experience: _____

Please attach these items to this completed sheet:

- 1) **An official copy of your high school academic transcript (Unopened)**
- 2) **Two letters of recommendation, one must be from an instructor**
- 3) **A one-page statement of your personal and academic goals and accomplishments**
- 4) **A signed Public Venue Release Form, signed by your parent/guardian if you are under 18**
- 5) Photo (Optional)
- 6) **** If additional space is needed, please attach**

Return completed applications to: High School Counselor's Office

Updated: 2/21/2024

Office Use Only - Review Date: _____
Signed by: _____

MGHF Auxiliary Board Review Date: _____
Approved: _____ Rejected: _____ Pending Further Review: _____

The undersigned hereby consents to the use of their personal information as identified below, by Public Hospital District No. 1 of Mason County, WA (doing business as Mason Health) and waived the right to inspect or approve such photos, stories, etc. or to receive any monetary compensation for this photo, story, etc. **A copy of this release form may be provided upon request.**

This information will be used for the following marketing campaign/purpose _____

The following Personal Information about myself or child may be used:

- Name (Please print) _____
- Name of Baby/Child (Please print) _____
- A photograph (picture) of myself
- A photograph (picture) of child
- Company Name _____
- The following information (attach a separate sheet if needed) _____
- Date of Birth _____

Please provide your contact information so we may contact you if necessary. This information will not be shared.

Home Address	Email
City, State, Zip	Phone Number

I agree that my information may be used in all of the following publications, except _____

- Mason Health Web Page
- Internet and Telephone Directories
- Newspapers and Happenings Newsletters
- Radio and Television
- Scope, Making the Rounds or other District Publications
- Reader Board
- Digital Stories, DVD's, as well as any and all social media and web based (and other) media outlets
- Any Years of Service recognition for duration of employment
- Individual Physician or Allied Health Profiles
- Educational material, i.e. flyers, banners, pamphlets
- Donor or Volunteer Recognition
- MGH Foundation Publications
- In the case of digital stories, videos, etc. I have reviewed the materials produced and I approve the final digital story/DVD that has been produced

Signature of Client or Legal Guardian _____ Date _____

Revocation of Public Venue Release

If, in the future, you no longer want Public Hospital District No. 1 of Mason County, WA, to use your information in a public venue, you need to contact Mason Health and sign a revocation statement. This can be done in person or via a fax notice to 360-427-1921.

I no longer want my personal information used in a public venue. I understand that it may take up to 60 days for this revocation to be put into effect.

Signature _____ Date _____

Return this form to the
Mason Health Development Office
 PO Box 1668
 Shelton, WA 98584
 Call 360-427-3623 or email
 foundation@masongeneral.com
 if you have questions.

PUBLIC VENUE RELEASE FORM
 Mason Health
 PO Box 1668, 901 Mountain View Drive
 Shelton, WA 98584