

# NHSHP Richard Madden and Linda Doerr Memorial Scholarship Award Application

|  |  |
| --- | --- |
| **Name** (Last, First, Middle) |  |
| **College/ School of Pharmacy** |  |
| **Anticipated Year of Graduation from Doctor of Pharmacy Program** |  |
| **Year in Pharmacy School (i.e., completed 3 years of a 6 year program)** |  |
| **Permanent Home Address** |  |
| **Mailing Address** (if different) |  |
| **Phone Number** |  |
| **Email** |  |

Please submit this application page along with the following documents:

* **Photocopy of Student ID**
* **Letter of Interest (No more than 500 words):** Describe why you believe you should be the recipient of the NHSHP student scholarship. **Please include any** relevant extra-curricular activities, activities which demonstrate leadership roles or activities that you have participated in, as well as your future leadership-related goals. If there are special circumstances you believe the Scholarship Committee should know about you, please describe them as well.
* **CV:** This should include descriptions of your involvement in national, state, and student organizations, pharmacy work experience, community service, honors and awards
* **Official Transcript:** This should include your cumulative GPA
	+ This should be an official transcript sent from your school
* **1 Letter of Recommendation**
	+ Letter should be from a professional who can speak about your activities and leadership roles
	+ Letter should be mailed or emailed directly from the letter of recommendation writer
	+ Applicants should use the “Letter of Recommendation Guidance” document when requesting letters of recommendation. This includes question prompts for the recommendation. It also includes information on the scholarship purpose, eligibility, and evaluation criteria.

The **Scholarship Application, Photocopy of Student ID**, **Letter of Interest**, and **CV** should be emailed to mmortimer@elliot-hs.org. An **Official Transcript** and **Letters of Recommendation** are to be mailed as follows:

Molly Mortimer

Pharmacy Department, Elliot Hospital

1 Elliot Way

Manchester, NH 03101

**Student Affidavit**

I hereby certify that the information contained herein is correct and complete and that I will use the proceeds of any aid awarded only for payment of direct educational and other college-related expenses. I understand that conditions for receiving scholarship aid, from the NHSHP Scholarship Committee, are contingent upon maintaining satisfactory progress toward graduation and that failure to comply with these requirements could result in the revocation of any awards for the current school year.

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

Applicant Signature Date