

## **The Manz Family Healthcare Scholarship**

Application Guidelines & Form

Award Amount: \$1,000

Deadline: March 1

### **Scholarship Purpose**

The Manz Family Healthcare Scholarship was established to honor the memory and legacy of the Manz family, whose lives exemplified compassion, community, and a deep respect for the healing professions. This scholarship supports individuals pursuing careers in healthcare who demonstrate a commitment to serving others, improving lives, and strengthening the well-being of their communities.

### **Eligibility Criteria**

Applicants must:

Be a resident of Phillips County Kansas.

Be a graduating high school senior or adult learner (e.g., non-traditional student, returning learner).

Plan to pursue a degree or certification in a healthcare-related field (e.g., nursing, physical therapy, medicine, radiology, paramedic, dentistry, laboratory, etc.).

There is no minimum GPA requirement.

Demonstrate a commitment to service, compassion, and helping others.

### **Required Materials**

To be considered, applicants must submit:

1. Completed Application Form (see below)
2. Personal Essay (500–750 words): Describe why you are pursuing a career in healthcare, what personal experiences or values have inspired you, and how you hope to make a difference in your community.
3. One Letter of Recommendation from a teacher, employer, healthcare professional, or community leader.
4. Transcript (high school or most recent college transcript, unofficial accepted).

### **Selection Criteria**

Applications will be reviewed based on:

- Strength and sincerity of personal essay
- Demonstrated commitment to healthcare and service
- Community involvement/Volunteerism
- Academic effort and character
- Quality of recommendation

### **Award Details**

- Two, \$1,000 scholarships will be awarded annually. (\$500 each semester upon proof of enrollment)
- The award may be used for tuition, books, or other educational expenses.
- Payment will be made directly to the educational institution upon proof of enrollment.

### **Application Form**

#### **Applicant Information**

Full Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

High School or College: \_\_\_\_\_

Expected Graduation Date: \_\_\_\_\_

Planned College/Program: \_\_\_\_\_

Healthcare Field You Intend to Enter: \_\_\_\_\_

#### **Signature**

I affirm that the information provided is true and accurate to the best of my knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please return all application materials by March 1 to:

[director@phillipscofoundation.org](mailto:director@phillipscofoundation.org)