Katie Robards Memorial Education Scholarship Application

OBJECTIVE:
To financially assist Johnson County residents pursuing careers in a health-related field at any recognized and accredited college or university in Indiana. This memorial scholarship is given on behalf of Katie Robards, a caring nurse for more than 40 years at Johnson Memorial Hospital.

SCHOLARSHIP AWARD:
The Katie Robards Memorial Education Scholarship will award several scholarships in the amount of $500-$1,000 for the academic school year 2026-2027. The amount will be paid directly to the school upon proof of registration by the college or university. Funds may only be used for tuition, payment of books and/or materials.

ELIGIBILITY:
1. Applicant must be a Johnson County resident.
2. Applicant may be a high school senior, a home-schooled student with proof of SAT scores, or an adult.
3. Applicants must be pursuing a degree in a health-related field.

BASIS OF AWARDING SCHOLARSHIP:
The scholarship will be awarded based on financial need and long-term goals.

APPLICATION:
Applicant must submit a completed application form (according to guidelines and deadlines).

APPLICATION DEADLINE:
A complete application must be sent to the Johnson Memorial Hospital Foundation and postmarked by April 1, 2026. Applications that do not conform to the requirements will not be considered.

JOHNSON MEMORIAL HOSPITAL FOUNDATION

SUBMIT APPLICATIONS TO:
Johnson Memorial Hospital Foundation
c/o Katie Robards Memorial Education Scholarship
1125 West Jefferson Street
Franklin, IN 46131
Email: foundationmail@johnsonmemorial.org
Questions, please call 317-346-3703

Katie Robards Memorial Education Scholarship Application

Name: _____

Street_____ City_____ State_____ Zip_____

Home Phone: _____ Cell Phone: _____ Email_____

Parents/Guardian Name(s) (if applicable)_____

IF HIGH SCHOOL SENIOR - COMPLETE THIS SECTION ONLY:

High School(s): _____Graduation Date_____

Number of Students in class: _____ Current Class Rank: _____ Cumulative GPA: _____

Career/Degree you will pursue:_____Year of college graduation (est.)_____

College/University you plan to attend:_____

IF COLLEGE STUDENT - COMPLETE THIS SECTION ONLY:

High School(s) attended: _____

College/University currently attending or planning to attend:_____

Degree you are pursuing:_____ GPA (if currently attending):_____

Expected Year of Graduation: _____

FINANCIAL INFORMATION:

Household Annual Income: $_____ Number of people living in your home:_____

Please explain any circumstances that would help us determine your financial need:

_____

_____

_____

_____

_____

(Continued on page 2)

Please indicate other scholarships, grants or loans received or applied for:

Scholarship/Grant _____ Amount of Award $_____ Pending ☐ Awarded ☐ Rejected ☐
Scholarship/Grant _____ Amount of Award $_____ Pending ☐ Awarded ☐ Rejected ☐
Scholarship/Grant _____ Amount of Award $_____ Pending ☐ Awarded ☐ Rejected ☐
Scholarship/Grant _____ Amount of Award $_____ Pending ☐ Awarded ☐ Rejected ☐

Please provide a brief explanation of how you intend to use the funds requested:

_____

_____

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_____

Please provide a brief explanation of your long-term goals/plans as they pertain to a career in health care:

_____

_____

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_____

_____

☐ I hereby affirm that the information provided on this application is accurate and complete to the best of my knowledge. Falsification of information may result in disqualification and/or termination of any scholarship granted.

Name _____ Date _____

Application Checklist

☐ Application Form

☐ Transcript from the educational institution most recently attended (official transcript not required - transcripts from high school or college website should provide name, school name, courses taken, grades, grade points, gpa)