



Catholic Health Good Samaritan University Hospital

Good Samaritan Hospital Foundation Lorraine Pace College Scholarship Program 2025 Application Guidelines and Instructions

Purpose: The purpose of the Good Samaritan Hospital Foundation Lorraine Pace College Scholarship Program is to assist students, who have had a parent, legal guardian or have been themselves, diagnosed with cancer, pursue their educational goals. It is designed to provide two one-time awards of \$2,000. The scholarship is NOT need-based. Criteria for consideration includes community involvement and personal commitment and is solely the decision of the Scholarship Committee of the Good Samaritan Hospital Foundation.

Eligibility:

- Have had a parent, legal guardian or themselves diagnosed with cancer.
- You must be a high school senior who will graduate by June 2024.
- A resident of Amityville, Babylon, Bay Shore, Bethpage, Bohemia, Brentwood, Central Islip, Commack, Copiague, Deer Park, East Islip, Farmingdale, Hicksville, Islip, Lindenhurst, Levittown, Massapequa, North Babylon, Plainview, Oakdale, Old Bethpage, Ronkonkoma, Sayville, Seaford, Smithtown, Wantagh, West Babylon, West Islip, Wyandanch, NY school district or parent/guardian is a resident.
- Have been accepted to, and plan to attend, a two or four year college or university or accredited vocational school upon graduation.
- Be a U.S. citizen or permanent resident of the U.S.

The applicant is responsible for ensuring that all items listed below are submitted as one package and postmarked by Friday, April 4, 2025.

- 1) Completed application
- 2) Personal essay
- 3) Two letters of recommendation
- 4) Acceptance letter from college/university/vocational school
- 5) Physician's letter supporting a cancer diagnosis (medical information will be kept confidential and will only be utilized to qualify consideration for the scholarship)

Mail to: Good Samaritan Hospital Foundation
 Scholarship Committee
 1000 Montauk Hwy.
 West Islip, NY 11795



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Employment/Internships/Summer Activities

| Company | Description of Role/Job Title | From-Thru | Hrs./week |
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Essay:

Include a personal essay between 500 to 1,000 words on how cancer has affected your outlook on life and how that might influence you moving forward toward your goals.

Essays must be typed and in English.

Letters of Recommendation:

Two letters of recommendation are required. One from a current academic teacher and one from someone you know (NOT a relative) referencing your personal qualities. Letters must be in a sealed envelope with the writers signature across the seal.

Acceptance Letter:

Include a copy of the acceptance letter to the college/university/vocational school you will be attending.

Physician's Letter:

A letter on the treating physician's letterhead verifying the diagnosis of breast cancer for your parent/legal guardian/self.



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Signatures:

I agree and consent to the use of my name, likeness, and/or personal story if I am chosen as a winner of the Good Samaritan Hospital Foundation Lorraine Pace College Scholarship Program. I understand that I will not be provided with any compensation for this use, and that my name, likeness and/or personal story may be used, at the discretion of the organization in print, television, radio, or electronic media.

Student's signature

Date

Parent/Guardian signature

Date

- Patient
- Employee
- Physician
- Board member
- Volunteer
- Community member
- Posed as patient
- Other _____



**Catholic
Health**

992 North Village Avenue
Rockville Centre, NY 11570

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SUBJECT'S NAME: _____

SUBJECT'S AGE: _____ (ONLY if subject is under 18 years of age)

for submission to various news media for publication as well as advertising, education, telecasts, research, pamphlets, web pages, fund raising and/or any other purpose by Catholic Health, together with its assignees, directors, agents, officers, volunteers, employees and their successors, releasing it and them from any legal responsibility or liability thereof, and waive any and all claims for payment or royalties.

I release Catholic Health or the person or entity designated by it from any liability by virtue of any blurring, distortion, alteration, optical illusion or use in composite form whether intentional or otherwise, that may occur or be produced in any processing toward the completion of the finished product.

Information about person giving consent:

NAME: _____

ADDRESS: _____

PHONE: _____

SELECT ONE: Self Parent Guardian Advocate Other: _____

I, the undersigned, have fully informed myself of this consent, waiver of liability and release before signing it. I understand I can stop the photograph or video process at any time. This consent remains valid unless or until I rescind it by writing to Catholic Health Public & External Affairs, 992 North Village Avenue, Rockville Centre, NY 11570.

SIGNATURE: _____ DATE: _____

RESTRICTIONS: _____

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Copy to be filed in Public & External Affairs.