



FOUNDATION

West Nebraska Blood Center Scholarship Application

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

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Email address: _____

High school from which you graduated: _____

Address of high school: _____

Graduating class rank: _____

Graduation date: _____ GPA: _____

Are you presently enrolled in college? Yes/No

What college will you be/are attending? _____

What is your major? _____

Which laboratory medicine profession do you intend to pursue? _____

Undergraduate year: Freshman _____ Sophomore _____ Junior _____ Senior _____

What is your current college GPA? _____ (unless applying for freshman collegiate year)

Estimated cost of next academic year beginning _____
Month _____ Year _____

Tuition: _____ Fees: _____ Books: _____

Other (please explain): _____



Please attach a formal letter of application. The letter should include an explanation of your interest in the chosen laboratory medicine field, future career plans, and a brief account of your financial reasons for applying for this scholarship. Any other information which may be relevant to the selection process may also be included in the letter.

I certify that the information on this application (and application letter) is complete and accurate. If selected, I intend to use this scholarship in the pursuit of a career in the field of laboratory medicine.

Please submit this application by **April 30, 2026**, along with all required attachments, to:

Regional West Foundation

Mailing address: 4021 Avenue B, Scottsbluff, NE 69361

Physical address: St. Mary Plaza, 3701 Avenue D, Scottsbluff, NE 69361

Email address: Foundation@rwfs.org

Applicant's name (print)

Applicant's signature

Date

Consent To Interview, Record, Film, Or Photograph

____ I, hereby authorize the duly appointed representative of Regional West or designated agent to interview me and to take such recording, film, or photograph of me if awarded a scholarship on behalf of Regional West Foundation.

I understand the purpose of the use of my name, recording, film, or photographs. I further understand that I have the right to request the recording, film, or photography be stopped at any time while it is occurring, and that I have the right to rescind consent for the use up until a reasonable time before the media is used.

I agree to hold Regional West physicians, providers, employees, and agents free and harmless from any and all liabilities, costs, damages, or ill effects that might arise from the expansive use or publication of any use of my name, recording, film, photograph, or other information made in accordance with this Consent.

I understand this Consent shall be valid until informing Regional West in writing of my intent to revoke.

I understand that a recording, film, photograph, or information made pursuant to this Consent may not be protected by federal privacy rules if further disclosed.

I will not take or distribute video, recordings, or photographs of any Regional West employee or provider without their consent.

Printed name of subject or legal representative (if a minor)

Date

Signature of subject or legal representative

Relationship to subject