HUNTER'S MEMORIAL SCHOLARSHIP FUND
IN MEMORY OF BILL LAWTON AND CAROL GILLOOLY
APPLICATION FOR FINANCIAL AWARD

The Hunter's Scholarship Fund in Memory of Bill Lawton and Carol Gillooly has been established in memory of William R. Lawton of Killingworth, Connecticut and Carol A. Gillooly of Middlefield, Connecticut, who lost their lives in the line of duty as Emergency Medical Technicians when struck by a drunk driver on September 2, 1989.

The Memorial Fund has been established for the purposes of providing education programs, training programs, and financial awards for educational related expenses to individuals pursuing or furthering their education or training in the fields of emergency medical services, healthcare, and related fields in their communities, including but not limited to physicians, physician's assistants, nurses, certified nursing assistants, and police and fire personnel.

ELIGIBILITY CRITERIA

To be considered for a financial award, every Applicant must provide the following:

- A completed, signed and dated Application form and Checklist
- A Personal Statement and 2 Letters of Recommendation (details are on page 6)
- Proof of successful completion of the following programs during the time period beginning January 1, 2025 through the application deadline, as follows:
    - For EMTs and Paramedics, a transcript or letter from your instructor evidencing proof of your successful course completion
    - For Allied Health Degree Programs, a transcript from the school evidencing your successful semester completion with a GPA of 3.00 or higher
    - For other Allied Health Certificate Programs, a transcript or letter from your program instructor/ director evidencing proof of successful program completion

SELECTION PROCESS

The Selection Committee will consider the following in making their selection(s) for a financial award:

- Academic Achievement
- Activities, Community Involvement, Honors and Recognition
- Financial Information
- Personal Statement
- Letters of Recommendation

DEADLINE TO APPLY

In order to be considered for a financial award, in addition to meeting the Eligibility Criteria, this application, all supporting documents, and letters of recommendation must be either

- Hand-delivered to 450 West Main Street, Building 3, Meriden, Connecticut on or before 4:00 p.m. on or before Friday, July 18th, 2025 or
- Mailed and Postmarked by Tuesday, July 15th, 2025 to the attention of "Memorial Fund Selection Committee, 450 West Main Street, Building 3, Meriden, CT 06451"

NOTIFICATION Applicants receiving a financial award will be notified on or before July 31st, 2025

NUMBER OF AWARDS AND AMOUNT AWARDED

The number of awards and amount awarded varies from year to year based upon the availability of funds and the number of eligible and deserving applicants.

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CHECKLIST

Initial each item to be sure your Application is complete and
Return this Checklist with your Application form.

_____ Completed, signed and dated Application form

_____ Transcript or Letter from school or instructor regarding successful Program Completion as noted in Eligibility Criteria

_____ Personal Statement

_____ Two letters of recommendation, dated and signed

INCOMPLETE OR LATE APPLICATIONS WILL NOT BE CONSIDERED

APPLICATION FOR FINANCIAL AWARD

[Please type or print the information requested legibly. Attach additional pages if needed.]

Applicant Information

Name: _____

Mailing Address (Street, Apt #): _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone # _____

E-Mail Address _____

Award Category

_____ EMT _____ PARAMEDIC _____ OTHER ALLIED HEALTH PROGRAM

Program Information

EMT or Paramedic Program? YES _____ (Complete Section A)

In a Allied Health College Degree Program? YES _____ (Complete Section B)

Other Allied Health Program? _____ YES (Complete C)

SECTION A. EMT or PARAMEDIC PROGRAM

Program Sponsor and Instructor Name:

_____

Location: _____ Date of Completion: _____

Type of Course (circle one): Pass/Fail or Graded: Grade Received (if applicable): _____

SECTION B. ALLIED HEALTH DEGREE PROGRAM

College/University _____

Degree Seeking:_____ Semester Completion Date: _____

Major & Minor Concentration(s)_____

Credits Earned to Date _____ Accumulated GPA _____

Expected Date of Graduation: _____

SECTION C. OTHER ALLIED HEALTH PROGRAM

PROGRAM SPONSOR/SCHOOL _____

Course of Study:_____

Date of Completion and Certification Earned: _____

Please Provide Information on work experience since 2008 to the present

Dates of Employment	Employer	Position
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Extracurricular Activities, Organization Memberships and Community Involvement

Please provide information on your school activities, groups or clubs; organization memberships; and community involvement, including your roles and responsibilities.

_____

_____

_____

_____

_____

_____

_____

Special Achievements, Honors & Recognition

_____

_____

_____

_____

_____

Financial Information

Please provide information/evidence regarding program fees and expenses you paid for which you are seeking a financial award. Please also indicate if you have received or expect to receive any other financial awards, scholarships or reimbursements for your program expenses. If you have, indicate who awarded or will be awarding the funds; the amount you received or will receive; and the date funds were awarded or by which you expect to receive the funds.

_____

_____

_____

_____

Personal Statement

Please attach a personal statement, not to exceed 300 words, about your educational and career objectives, long-term goals, and tell us about the experiences that have influenced your decision to pursue a career in the healthcare field and how those experiences will help you in your career choice.

Letters of Recommendation

Please provide two letters of recommendation from responsible persons (excluding family/relatives, members of the Selection Committee or Foundation) who are well acquainted with your educational background, personal character and career goals. This application will not be considered unless the two letters of recommendation are received. The letters must be dated, signed and either submitted with this application or forwarded directly to the attention of "Memorial Fund Selection Committee, Building #3, 450 West Main Street, Meriden, CT 06451."

Applicant Certification

I certify that the information provided is complete and accurate to the best of my knowledge. If requested, I agree to give proof of any information I have given on this form. Falsification of information may result in forfeiture of any financial award. I understand that the Selection Committee will maintain this information as confidential and I acknowledge all decisions of the Selection Committee are final.

Signature _____ **Date** _____

Printed Name _____

DATE RECEIVED IF HAND-DELIVERED: _____ **POSTMARK DATE IF MAILED:** _____