

**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, 2026 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, August 12, 2026; or
- Mailed and postmarked by Tuesday, August 4, 2026 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 September 2, 2026.

## **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 2018 to the present**

<b>Dates of Employment</b>	<b>Employer</b>	<b>Position</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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.

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**Special Achievements, Honors & Recognition**

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**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 awarded the funds; the amount you received or will receive; and the date funds were awarded or by which you expect to receive the funds.

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**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 people (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:** \_\_\_\_\_