

**Northern Stateline Regional Health Care Initiative
Scholarship Application
2010**

APPLICANT

Name _____
(first) (middle initial) (last)

Mailing Address _____
(street address/apt no./ P.O. Box)

(city) (state) (zip)
Date of Birth _____ County of Residence _____

Telephone (____) _____ Cell Phone (____) _____

Email Address _____ Social Security Number _____

Female Male Date of Birth __/__/__ Marital Status S M D W

Number of Dependents under the age of 18 residing with you? _____

Are you a citizen? Yes No

If no, Are you a Resident Alien authorized to work in the United States? Yes No
Number _____

Race/Ethnicity: American Indian or Alaskan Native Asian Black Hawaiian or Pacific Island White
 Prefer Not to Answer

Hispanic or Latino Yes No

Disability: Yes No If Yes, Complete the following information:

<u>Disability Status</u>	<u>Category of Disability</u>
<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Physical Impairment
<input type="checkbox"/> Disability Affecting Employment	<input type="checkbox"/> Mental Impairment
<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Both
<input type="checkbox"/> Undisclosed	

Veteran Status: Not a Veteran Veteran Qualified Spouse of a Veteran Transitioning Veteran

If you have checked Veteran or Qualified Spouse of a Veteran above, complete the following:

Branch of Service: _____ Dates of Service: From __/__/__ To __/__/__

Nature of Military Discharge: Honorable Dishonorable Less than Honorable
 Service Connected Disability

Armed Forces Campaign or Expeditionary Medal Yes No

Service Connected Disability Yes No U.S. Citizen at time of Service Yes No

Copy of DD214 Provided Yes No

EDUCATION

Have you had prior healthcare education? Yes No

If yes, what type? Associate degree Hospital-based diploma Baccalaureate Degree Certificate
Major for Degree(s) _____

* Do you have a current Illinois license in nursing? Yes No

If yes, name _____

*In which **nursing program** or **healthcare program** have you been accepted in and enrolled during 2010?

Practical Nursing Associate Degree Baccalaureate Degree Graduate Degree

On-Line Pre-Licensure On-Line Graduate

Other, explain _____

Name of school where you are/will be enrolled during 2010?

During 2010 you will be enrolled:

Full-time (12 credit hours or more) Part-time (less than 12 credit hours)

Anticipated date (month/year) of graduation? _____

EMPLOYMENT

Please check any current and previous areas of specialty and years of experience:

<input type="checkbox"/> Ambulatory/OP/Clinic/Office _____	<input type="checkbox"/> Community/Home Health _____	<input type="checkbox"/> ER _____
<input type="checkbox"/> Geriatrics _____	<input type="checkbox"/> Med/Surg _____	<input type="checkbox"/> ICU/CCU/Telemetry _____
<input type="checkbox"/> NICU/Neo _____	<input type="checkbox"/> OB/GYN _____	<input type="checkbox"/> Oncology _____
<input type="checkbox"/> Ortho _____	<input type="checkbox"/> Pediatrics _____	<input type="checkbox"/> Psych _____
<input type="checkbox"/> Neuro _____	<input type="checkbox"/> OR _____	

Employer _____ Current Position _____

Employers Address _____
(Address)

(City) _____ (State) _____ (Zip) _____ (County) _____

Hourly Wage _____ Employment Benefit Hours _____

*Anticipated employer Tuition Reimbursement \$ _____

Are you receiving other sources of financial aid that might commit you to work as a nurse outside of Illinois? Yes No

DOCUMENTATION

*To be considered in the selection process, an applicant must:

- 1) Submit an original complete, signed and dated application;
- 2) Include a copy of your Illinois registered professional license or Illinois Practical nurse license if applicable;
- 3) Include a verification of employment and endorsement of tuition reimbursement eligibility;
- 4) Include verification of acceptance in to a qualified program with intended start date.

Application must be submitted to:
Pamela Fettes
The Workforce Connection
Nursing Education Scholarship Program
303 N. Main Street
Rockford, IL 61101

Scholarships will be awarded based on availability of funds.

RELEASE/CERTIFICATION STATEMENT

I hereby agree that the Rockford Regional Nursing Collaboration may verify any and all statements in this application and future nursing employment documentation that may be relevant to the discharge of the scholarship obligation. I grant permission to any and all persons and institutions to release all information requested by the Northern Stateline Regional Healthcare Collaboration and further agree that the Northern Stateline Regional Healthcare Collaboration may release such information to appropriate persons and institutions. I certify that I am not presently in default on payments for any previously received state or federal educational funds. I also hereby certify that the information submitted in this application is a true record.

*

Applicants Signature

Date

EMPLOYMENT/EDUCATION STATEMENT

I hereby agree that I have no current plans to relocate outside of the Northern Stateline Region and I fully intent to continue working for my current employer for a period agreed to with my employer. I also agree that if I am receiving assistance to acquire a graduate level degree I will be available on a basis to be determined to offer education assistance in some capacity.

*

Applicants Signature

Date