	DEACONESS HOSPITAL SCHOOL OF NURSING ALUMNI ENTRY LEVEL NURSE SCHOLARSHIP PROGRAM	

APPLICATION

Please print or type

NAME______________________________ **Email Address**____________________

ADDRESS____
Street or Box Number City State Zip

COUNTY_________________________ **TELEPHONE (   )**__________________

I hereby release the information provided with this form and authorize the examination of my permanent record by the Deaconess Hospital School of Nursing Alumni Board of Directors for this purpose only. (Disclaimer 1974 Freedom Information Act)

DATE ________________ **SIGNATURE**_________________________________

The Deaconess Hospital School of Nursing Alumni will offer scholarships up to $15,000.00 to be distributed to the most qualified applicants of direct descendants of graduates of the Deaconess Hospital School of Nursing in Evansville Indiana or current Deaconess Hospital Employees. **The scholarship has been established for the express purpose of providing assistance to a student pursuing education in order to obtain a license for Registered Nursing.** These monies may be applied toward tuition, books, fees, and/or living expenses for the individual.

The individual selected must meet the selection criteria:

1. Submit a one page narrative addressing three (3) predetermined questions.
2. Meet the admission criteria of the institution in which the individual desires to pursue higher education.

Recipients of the Deaconess Hospital School of Nursing Alumni Scholarship that are also participating in the Deaconess Hospital Employee Assistance Program may only use the scholarship toward books, living expenses and fees, not tuition. If the scholarship is used toward tuition expenses, it will be deducted from the amount of Education Assistance received through the Employee Assistance Program.

Forms to be mailed to:
DHSON Alumni Scholarship Committee
600 Mary Street
Evansville, IN 47710

Deadline for acceptance of applications is the second Friday of March annually.
The award will be announced to the applicant by first week of May annually.

Web address: http://www.deaconess.com **Directions to access form**: **Select**: > For You; > Health Professionals; > School of Nursing Alumni; > Educational Funds; > Descendant Scholarship Form

EDUCATIONAL INFORMATION

GED/HighSchool/College		Attendance Dates		Degree/Diploma

Name and location of NURSING PROGRAM (college/university):

____

During the Fall Semester will you be a Freshman ____, Sophomore______, Junior_____, Senior______ in the Nursing program?

Predicted Graduation Date:________________

EMPLOYMENT INFORMATION

Present Employment________________________ Hours per week______________

Job title or description____

How long employed? ____________________ Rate of pay $___________

FINANCIAL ASSISTANCE

List any scholarships or financial aid you are receiving from Veteran Benefits, Social Security, Federal or State aid, tuition from an employer or other source:

SOURCE	AMOUNT

OTHER INFORMATION

Submit a one page narrative addressing the following questions:

1. What causes you to choose Nursing as a career?
2. Why are you seeking this scholarship?
3. What will the field of Nursing gain from your education?

I, the undersigned, hereby certify that the facts above are true. I further understand that if I fail to complete this questionnaire or if the information is found to be incorrect, my application will not be considered. I further understand that if I am awarded a scholarship, and it is later determined that I have falsified any pertinent facts in the above application or terms of the contract, I will be required to repay the scholarship funds.
I hereby authorize the Deaconess Hospital School of Nursing Alumni Board of Directors to investigate all information contained in this application and release all persons, corporations or other institutions from all liability and responsibility for furnishing additional information or confirming the data given in this application.

Date: ________________ Signature:____________________________________

Relationship required by Scholarship:

______The descendants of graduates of the Deaconess Hospital School of Nursing in Evansville Indiana
____________Current Deaconess Hospital Employees
____________The direct descendants of current Deaconess Hospital Employees

Graduate Name:________________________________ Year of Graduation:___________

Employee Name:________________________________ Department:_________________

Codicil:

The Deaconess Hospital School of Nursing Alumni Board of Directors is responsible for screening all candidates and selecting the award winner. It is the Alumni Member's desire that preference be given to scholarship applicants who are entering their first year of schooling in the pursuance of a Nursing License. If no applicants are enrolled in the first year of schooling, other applicants will be considered. The Deaconess Hospital School of Nursing Alumni Board of Directors will receive proof of attendance at a licensed school of Nursing for the applicant. The Board will receive annual proof that studies have been completed for the specified year. If no proof is received, the Scholarship will be considered a loan and will be repaid within a two year period, accruing interest are 5% annually. As the scholarship is to be used for tuition expenses, the check will be made payable to the institution.