DR. HELEN DUNN
NURSING GRANT
NORTHSHORE DISTRICT NURSES ASSOC.
APPLICATION FORM

CRITERIA:

1. Must be resident of Washington or St. Tammany Parish.
2. Must be seeking as AD, BSN, or higher degree.
3. Must be attending an NLN accredited school of nursing and successfully completed at least one semester of nursing courses.
4. Must have a minimum GPA of 2.5.
5. Persons in financial need given preference.
6. NDNA Board approval necessary for all/any exceptions to the above.
7. References will be checked as to attendance at named school at time of application and after receiving monies. (You may enclose a letter verifying attendance with application.)
8. Amount of grant: Minimum of $250 per year. Maximum $1000 per person per degree acquired over a 3-year period.

MAIL APPLICATION TO:

Southeastern Louisiana University

School of Nursing

SLU 10835

Hammond, LA. 70402

CONTACT:

Willa Stewart Willa.Stewart@selu.edu

NAME:____ SS#:______________________

FIRST MIDDLE LAST

ADDRESS:____

STREET CITY ZIP

PHONE: HOME __________________ WORK ____________________ CELL___________________

PRESENTLY EMPLOYED?: _______ YES _______ NO

PLACE OF EMPLOYMENT: ____

POSITION: ____________________________ HOURS: _______ FULL-TIME _______ PART-TIME

Complete the following or attach a resume to include:

LIST 3 PRIOR EMPLOYERS:

	EMPLOYER	CONTACT PERSON	ADDRESS	PHONE	DATES EMPLOYED
1.					
2.					
3.					

EDUCATION HISTORY: (High School, other training, certificates, degrees)
**Transcript of nursing courses MUST be received before grant is awarded.

SCHOOL	CITY	CERTIFICATE, DEGREE, ETC.	DATE RECEIVED

GOALS FOR CONTINUED EDUCATION:

DEGREE SOUGHT: ____

ANTICIPATED DATE OF GRADUATION:____________________________

COURSES AND NUMBER OF CREDIT HOURS TAKING OR PLANNING TO TAKE (specify which):

COST PER SEMESTER:_____________________ COST FOR BOOKS: _______________________________________

PLANS FOR EMPLOYMENT POST GRADUATION:

<u>STATEMENT OF FINANCIAL NEED</u>: (Financial disclosure is optional, but may affect the selection committee's decision if omitted.)

NUMBER OF DEPENDENTS: __________ AGES OF DEPENDENTS: _______________________________________

ARE YOU RECEIVING ASSISTANCE FROM OTHER SOURCES: _________YES _________ NO
(Compensation from employment, other grants, scholarships)

IF YES, PLEASE LIST SOURCES:

LIST MAJOR DEBT SOURCES:

LIST OTHER FACTORS YOU FEEL INDICATE A REASON YOU NEED FINANCIAL ASSISTANCE:

YOUR APPROXIMATE INCOME:____

SPOUSES APPROXIMATE INCOME: ____

PLEASE LIST PROFESSIONAL ORGANIZATIONS TO WHICH YOU BELONG:

PLEASE LIST CIVIC ORGANIZATIONS TO WHICH YOU BELONG:

WHO TOLD YOU ABOUT THIS SCHOLARSHIP:

__________ School posting

__________ Personal Individual

__________ Other (specify) ____

I hereby certify that all statements mede in this application are true and complete and submitted for the purpose of obtaining financial assistance for a nursing degree. If selected as a recipient, I agree to verify satisfactory completion of courses. In the event I discontinue my studies or fail to maintain the required grade point average, I agree to fully refund the full amount of the grant. I understand this is a single semester stipend. I must reapply each semester if I require additional/ ongoing funding.

____ ______________________________

SIGNATURE DATE

NDNA Action:

Received by: _____________________________________ Date received: ________________________

Information reviewed by: ____

GRANT: ________ YES Amount: _______________ Date approved: ____________________

Date check sent: __________________ Check #: _________________

________ NO Reason why denied: ____