

Deadline for submission: **November 1**



## Nursing Scholarship Application

☐ 1st Time Applicant    ☐ Re-applicant (previously approved)    ☐ Re-applicant (previously denied)

Name: \_\_\_\_\_ Current Semester: \_\_\_\_\_ Major/Degree: \_\_\_\_\_

**When you have completed this application, return it to:**  
**Trinity Health Foundation, 1250 21st Ave SE, Minot, ND 58701 - Phone: 701-857-2430**  
**Transcripts can be emailed to [foundation@trinityhealth.org](mailto:foundation@trinityhealth.org)**

The following documents are required for consideration of Trinity Health Foundation's Nursing Scholarship.

☐ **Application Form**

☐ **Letter of Acceptance:** Applicants must include a copy of their letter of acceptance to an accredited Nursing School.

☐ **Transcripts:** Applicant should arrange for official transcripts to be sent directly to Trinity Health Foundation. Registration with current semester's enrolled credits is also required.

☐ **Recommendations:** Applicants must include three (3) letters of recommendation. One recommendation must be from current nursing instructor and/or the applicant's Nurse Manager. The remaining recommendations should be from other non-family persons.

☐ **Essay:** Tell us about yourself and why you want to pursue a career in Nursing.

### WORK COMMITMENT:

Select the scholarship amount you are applying for (select one or both):

☐ **\$5,000** – Requires an **18-month** work commitment at Trinity Health after graduation.

☐ **\$10,000** – Requires a **2-year** work commitment at Trinity Health after graduation.

### EDUCATION:

Name of professional education program you are currently enrolled in: BSN \_\_\_\_\_ ADN \_\_\_\_\_

Name of school where you are enrolled: \_\_\_\_\_

Indicate the expected date (month and year) you will complete your education for the program you are currently enrolled in \_\_\_\_\_

Is this your 1st or 2nd year of the nursing program? \_\_\_\_\_

Specialized training, experience, licenses or certifications \_\_\_\_\_

# TRINITY HEALTH FOUNDATION NURSING SCHOLARSHIP APPLICATION

## PERSONAL INFORMATION:

|                 |                |                     |       |     |
|-----------------|----------------|---------------------|-------|-----|
| Full Legal Name |                | Social Security No. |       |     |
| Home Address    | No. and Street | City                | State | Zip |
| Home Phone      | Cell Phone     | E-Mail Address      |       |     |

## OTHER:

Have you ever had your name listed on a state directory for mistreatment, neglect or abuse of residents or misappropriation of their property? ☐ Yes ☐ No

Has your license to practice in any jurisdiction ever been denied, terminated, limited, revoked, suspended, voluntarily or involuntarily surrendered, relinquished, or subject to probationary terms, or is there a pending action or challenge to do so? ☐ Yes ☐ No

Do you know of any circumstances that would impact your ability to obtain a nursing license? ☐ Yes ☐ No

Have you ever been or are you currently in process to be excluded from participation in any State or Federal Health Care Program? ☐ Yes ☐ No

If you answered "yes" to any of the questions above, please explain completely.

Criminal convictions are not an absolute ban to receive scholarship funds but will be considered in relationship to the specific circumstances.

*I certify that the statements on this form are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this form. I agree that former employers or any other persons may furnish Trinity Health with all information regarding their records of my past service character and reason for leaving. I hereby release all former employers and persons from all liability on account of providing such information. I understand that misrepresentation or omission of information in connection with this application will be sufficient cause, in and of itself, for rejection whenever discovered.*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant