Jayne E. Miller Nursing Scholarship Awards

Criteria:

1. Applicant must be:
   - a full or part-time employee of Bethesda Hospital in good standing;
   - pursuing an accredited undergraduate degree in a nursing program; or
   - a Registered Nurse pursuing a Bachelor of Science Degree in Nursing.

   Members of the Board of Directors of the Auxiliary and their immediate family members are not eligible for this scholarship.

2. For consideration as a candidate for scholarship, the student must:
   - attend a nursing accredited program within the State of Florida;
   - have completed the first semester of college; and
   - have maintained a minimum 3.0 GPA.

3. Undergraduate Study:
   - The maximum award per semester is $750, and will be limited to 3.5 years of undergraduate study.
   - Scholarship awards are limited to two (2) semesters in a one-year period.
   - The minimum requirement for this award is nine (9) credit hours per semester.

4. Returnees have priority over new applicants. However, if a recipient
   - does not reapply for assistance in the course of the calendar year, or
   - does not inform the Auxiliary Office that he/she does not require a scholarship award for that semester, then …

   that individual will lose priority status and will have to reapply as a new applicant.

5. All applicants and continuing scholarship recipients must provide:
   - an Official Transcript;
   - the name and address of two (2) instructors as references; and
   - a letter from Human Resources indicating they are a Bethesda Hospital employee in good standing.

6. The scholarship check will be made payable to the College/University, and presented to the Scholarship recipient.

7. The ultimate decision of an applicant being accepted into the Scholarship Program will be at the discretion of the Board of Directors of the Auxiliary.

Committee:

Bobbi Hill
Joyce Honig
Linda Condon

THE AUXILIARY OF BETHESDA HOSPITAL, INC.

STUDENT APPLICATION OF HEALTH CAREER SCHOLARSHIP PROGRAM

Name:_____

Address:_____

Telephone:_____ **DATE OF BIRTH:**_____

MARITAL STATUS: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Widow** ☐ **Divorced**
If single, give occupation of father and mother, and ages of dependent brothers and sisters. If a parent, give number and ages of dependent children:_____
_____
_____

ANNUAL FAMILY INCOME:

☐ **$10,000 - $20,000** ☐ **$20,000 - $30,000** ☐ **$30,000 - $40,000** ☐ **$40,000 - $50,000** ☐ **Over $50,000**

GIVE INFORMATION CONCERNING HIGH SCHOOL AND OTHER SCHOOLS ATTENDED:

School	Name and Location	Course of Study	Number of Years Completed	Did you Graduate	Degree or Diploma
High School					
Colleges / Universities					
Vocational Training					
Other					

LIST THE ORGANIZATIONS OF WHICH YOU ARE A MEMBER:
_____
_____

AN OFFICIAL TRANSCRIPT OF GRADES 3.0 AVERAGE OR HIGHER <u>IS REQUIRED</u>. PLEASE ATTACH. NO APPLICATION WILL BE CONSIDERED WITHOUT THE <u>OFFICIAL</u> TRANSCRIPT.

NAME OF SCHOOL YOU ARE WHICH ATTENDING:_____

SCHOOL ADDRESS:_____
_____

YOUR MAJOR:_____

COST OF TUITION PER TERM:_____

NUMBER OF TERMS PER YEAR:_____

NUMBER OF TERMS TO GRADUATE:_____

DATE YOU BEGAN SCHOOL:_____

AMOUNT OF SCHOLARSHIP NEEDED FROM THE AUXILIARY:_____

LIST OTHER SOURCES OF FINANCIAL AID (Parents, part-time work, additional grants, scholarships, etc.):_____

_____

REFERENCES: Give full names and addresses of two instructors who are well acquainted with you
Name:_____

Address_____

Name:_____

Address:_____

IN THE SPACE BELOW EXPLAIN IN APPROXIMATELY 100 WORDS YOUR REASON FOR PURSUING A CAREER IN THE NURSING FIELD. (If necessary, use additional paper.)

_____ _____

Signature of Applicant **Date**

MAIL APPLICATION FORM, TRANSCRIPT AND A LETTER FROM YOUR STUDENT ADVISOR OR DEPARTMENT HEAD, CONFIRMING YOUR MAJOR AND INTENT TO PURSUE A CAREER IN THE HEALTH FIELD TO:

Bobbi Hill
Health Career Director
2815 South Seacrest Boulevard
Boynton Beach, Florida 33435

All information on this application form will be held confidential by the Health Career Committee.