**VDH-OHE-MARY MARSHALL NURSING SCHOLARSHIP PROGRAM**

**2019 APPLICATION- REGISTERED NURSES**

**APPLICATION CHECKLIST AND REQUIREMENTS**

**This checklist must be reviewed thoroughly and submitted as part of a completed application. Incomplete applications will not be considered for award and failure to comply with any of these application requirements will result in the applicant being ineligible for award.**

Mary Marshall Nursing scholarships are for students enrolled in undergraduate nursing programs. Undergraduate nursing programs are defined as those leading to a diploma, an associate degree, or baccalaureate degree in nursing. Under the law, all scholarship awards are made by an Advisory Committee appointed by the State Board of Health. The Office of Health Equity (OHE) of the State Health Department serves as the staff element to the Advisory Committee and has no role in the determination of scholarship recipients. The basis for determining scholarship recipients is established by the Advisory Committee with due regard given to scholastic attainment, financial need, character, and adaptability to the nursing profession.

Applicant must be a United States Citizen , National, hold an immigration visa or classified as a political refugee as verified by a social security number included in the application. **Persons with a temporary or student visa are not eligible**.

Applicant must be a resident of the State of Virginia for at least one year**.** Verification provided must prove that the applicant has lived in VA for at least one year (ex. Renewal date on driver’s license, previous year on voter registration card, motor vehicle registration/employment records/deed of property/ sources of financial support, etc if they reflect multiple years). Please provide one of the following appropriate forms of verification: 1.) State Income Tax record or statement 2.) Driver's license with renewal information 3.) Voter registration card 4.) Motor vehicle registration 5.) Employment record or 6.) Ownership of real property

Applicant must attach a Recommendation from authorized personnel at the current School of Nursing or the School of Nursing they plan to attend and have it returned to him/her to be submitted with the application. **“Section 6-School of Nursing Recommendation” must be printed at the top of the page.** The recommendation must be on the School of Nursing’s letter head and include the applicant’s name, current date, contact information and a signature. **Recommendations will not be accepted if not submitted as stated above.**

Applicant must attach a one page Narrative Summary. **“Section 7-Narrative Summary” must be printed at the top of the page. The applicant should sign and date the bottom of the page. (The Narrative Summary will not be accepted if not submitted as stated above.) In one page or less**, the summary must explain the significance of the Mary Marshall Nursing Scholarship in pursuing his/her educational goals, any school/community activities, and any skill-set that is pertinent to the nursing profession. It is important that the applicant consider and include plans for professional practice in Virginia following graduation. **If the Narrative Summary exceeds the one page limit, it will not be accepted**.

Applicant must be accepted to or enrolled in a school of nursing in the State of Virginia. The applicant must have the Registrar’s Office/Authorized Person at the institution currently attending or plans to attend in the upcoming 2019/2020 Academic Year complete **Section 8** and provide an **original signature** and have it returned to him/her to be submitted with the application. **Section 8 will** **not be** **accepted if it is not submitted with the application**

Applicant **must attach an appropriate grade transcript** from all schools attended. **The transcript will not be accepted if it is not submitted with the application**. The applicant must demonstrate a cumulative grade point average (GPA) of at least 2.5 if currently enrolled in and attending a nursing program.

Applicant must demonstrate financial need verified by the Financial Aid Office/Authorized Person. The applicant must have the Financial Aid Office/Authorized Person complete **Section 9** of the application, provide an **original signature** and have it returned to him/her to be submitted with the application. **Section 9 will** **not be** **accepted if it is not submitted with the application.**

**Applications must be typed and have all appropriate documents attached**. Applicants are advised to keep a copy for their records. Application open period is **May 1 to June 30** for the fall academic year. Applications are not accepted prior to May 1st, and must be **postmarked by June 30th.** Please mail completed applications to:

***Virginia Department of Health***

***Office of Health Equity   
ATTN: Workforce Incentive Programs  
109 Governor St., Suite 714 West Richmond, Virginia 23219***

**If you have any questions, please contact The Office of Health Equity at 804-864-7435.**

**SECTION 1 – PERSONAL DATA**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Application: | | | | | | | | |  |
| Legal Name: | | |  | | | | |  | | | | | | |  | |  |
| Preferred Name: | | | Last | | | | | First | | | | | | | MI | | Maiden |
| Address: | | |  | | | | | | | | | | | | | | |
|  | | | Street Address | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | |  | | |
| City | | | | State | | | | | | | | Zip | | |
| Day Phone Number: | | |  | | | | Evening Phone Number: | | | | | | | |  | | |
| Email Address: | | |  | | | | | | | | | | | | | | |
| Social Security Number: | | |  | | | | | | | Sex: | | |  | | | | |
| Date of Birth and Age: |  | | | | Place of Birth: | | | | | |  | | | | | | |
| Race/Ethnicity: |  | | | | Other: |  | | | | | | | | | | | |
| How long have you been a resident of Virginia? | | | | | |  | | | | | | | | | | | |
| Do you have an active military service obligation? | | | | | |  | | | | | | | | | | | |
| Congressional District: | | | | (Please check with your voter registration office or visit  http://nationalatlas.gov/printable/congress.html) | | | | | | | | | | | | | |
| Are you a high school graduate? | | | | | | | | Do you possess a GED? | | | | | | | | | |
| Are you a certified Nursing Aide (CNA)? | | | | | | | | | | | | | | | |  | |
| Have you ever received a Mary Marshall Nursing Scholarship? | | | | | | | | | | |  | | | | | | |
| If yes, in what year(s)? | |  | | | | | | | | | | | | | | | |
| If you had a different name when you applied previously, please provide it here: | | | | | | | | | | | | | |  | | | |
| What school of nursing were you attending during that time? | | | | | | | | |  | | | | | | | | |
| Do you speak another language? If yes, please list: | | | | | | | | | | | |  | | | | | |

**ALTERNATE CONTACT PERSON (OTHER THAN APPLICANT)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name: |  | |  | | | |  |
|  | Last | | First | | | | MI |
| Address: |  | | | | | | |
|  | Street Address | | | | | | |
|  | | |  | |  | |
| City | | | State | | Zip | |
| Phone Number: |  | Relationship to Applicant: | | |  | | |

**SECTION 2 – NURSING EDUCATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| School of Nursing: | | |  | | | | | | | | | | |
| Student Identification or Social Security Number: | | |  | | | | | | | | | | |
| Address: | | |  | | | | | | | | | | |
|  | | | Street Address | | | | | | | | | | |
|  | | | | |  | | |  | | |
| City | | | | | State | | | Zip | | |
| Phone Number : |  |  | | | |  |  | | | | | | |  | |  |
| Full-time Student: |  | Part-time Student: | | | |  | If part-time, how many credit hours are you taking? | | | | | | |
| Have you transferred to this school from another nursing program? | | | | | | | | |  | | | | |  |
| Name of previous school: | | | |  | | | | | | | | | |  |
| Date of enrollment in present Nursing Program: | | | | | Month | | | | | Day | | Year |
| Expected date of graduation: | | | | | Month | | | | | Day | | Year |

**Nursing Program Level: Please check the program type and current level. Specify level in September.**

|  |  |  |
| --- | --- | --- |
| Program | Current Level | Level in September |
|  |  |  |

**SECTION 3 – PRIOR EDUCATION**

*Please check the program types that you have successfully obtained.*

CNA LPN  AAS, RN BSN  other

Current License:      Current License Number:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | School | Diploma/Degree | City and State | Dates of Attendance | Reason for Leaving |
| 1. |  |  |  | to |  |
| 2. |  |  |  | to |  |
| 3. |  |  |  | to |  |

**SECTION 4 – WORK EXPERIENCE**

*Check here if you have never been employed, and skip to Section 5*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Position | Name of Employer | City and State | Dates of Employment | Reason for Leaving |
| 1. |  |  |  | to |  |
| 2. |  |  |  | to |  |
| 3. |  |  |  | to |  |

**SECTION 5 – OTHER HEALTH-RELATED AND/OR CIVIC EXPERIENCES**

*Check here if you have never been involved in any health related and/or Civic Activities, and skip to Section 6*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Position | Organization | City and State | Dates of activities |
| 1. |  |  |  | to |
| 2. |  |  |  | to |
| 3. |  |  |  | to |

**SECTION 6 – SCHOOL OF NURSING RECOMMENDATION**

**(Must submit as an attachment on a separate sheet on School Letter Head)**

Applicants should request a recommendation from authorized personnel at your **current** School of Nursing or the School of Nursing they plan to attend. Examples of personnel authorized to write your recommendation is not limited to but includes: Dean/Director/Chair, Academic Advisor, or Teacher/Professor. Applicants **must** label the top of the attached sheet **“Section 6-School of Nursing Recommendation”**, **Authorized Personnel:** Provide a recommendation on School of Nursing letter head that is unique to this applicant in one page or less. The recommendation that you write will be returned to him/her to be submitted with the application. Please address the following: scholastic achievements, character, adaptability, and/ or other attributes. The recommendation **must** be on the School of Nursing’s letter head and **must** contain the applicants name, current date, your contact information and a signature. **Recommendations will not be accepted if not submitted as stated above.**

**SECTION 7 – NARRATIVE SUMMARY (Must submit as an attachment on a separate sheet)**

Briefly explain, *in one page or less*, the significance of the Mary Marshall Nursing Scholarship in pursuing your educational goals. Also, include school and/or community activities as well as any skill-set that is pertinent to your profession. It is important that the applicant consider and include plans for professional practice in Virginia following graduation. Applicant **must** label the top of the attached sheet **“Section 7-Narrative Summary”**, print name, provide an original signature, and the current date. **If the Narrative Summary exceeds the one page limit, it will not be accepted**.

**SECTION 8 – SCHOOL OF NURSING ENROLLMENT CONFIRMATION**

***To be completed by the Registrar’s Office***/***Authorized Person of the School of Nursing the applicant is currently attending or plans to attend in the upcoming 2019/2020 Academic Year.***

1. Name of applicant:
2. Student Identification number or Social Security Number:
3. This applicant is:
4. Date of entrance: Month       Year
5. During this award period, the applicant will be a:
6. ***Currently enrolled in your Nursing Program:***

Provide a cumulative grade point average of current nursing courses. Applicants must have at least a 2.5 cumulative GPA in Required Nursing Courses, electives should not be considered in cumulative GPA.

GPA: List GPA

1. ***Applicant has enrolled in your Nursing Program:***

Select your Source of computing the GPA for entry into your program and the Cumulative GPA:

Source of computing GPA:

GPA: List GPA

***Provide an original signature from the Registrar’s Office***/A***uthorized Person completing this enrollment confirmation section.***

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Name of Authorized Personnel Completing This Section |  | Title |
|  |  |  |
| Signature |  | Date |
|  |  |  |
| Full Name of School of Nursing |  | Phone Number E-mail Address |

**SECTION 9 – FINANCIAL NEED ANALYSIS**

***To be completed and signed by the Financial Aid Officer or Authorized Person***

The Mary Marshall Nursing Scholarship is a need-based aid program. The need analysis below should be based on charges and eligibility for the 2019/2020 Academic Year i.e. Fall 2019, Spring 2020, and if applicable Summer 2020.

Financial Aid Officers/Authorized Person should use their recourses to provide the best *estimate* for all figures in the need analysis calculation.

**Federal Financial Aid Institutions** should require the applicant to complete the 2019/2020 FAFSA prior to completing this section and complete only the Questions in #3.

**Non-Federal Financial Aid Institutions** should have the applicant complete any documentation needed to provide you with the figures to complete the needs analysis and complete only the Questions in #4.

**Institutions should complete QUESTION 3 or 4, DO NOT COMPLETE BOTH.**

1. Applicant Name:
2. Student Identification Number or Social Security Number

|  |  |  |
| --- | --- | --- |
| 3. | **Federal Financial Aid Institutions need analysis:**  *\*To calculate Remaining Need:*  Unmet Need (a) minus (-) (Total Federal Grants (b) and Total Scholarships, and Discounts(c)) equals (=) Remaining need | |
|  | *Estimated* 2019/2020 Cost of Attendance |  |
|  | Expected Family Contribution (EFC) | (*minus)* |
|  | Estimated 2019/2020 Unmet Need *(a)* | *(equals)* |
|  | *Estimated* Total 2019/2020 Federal Grants *(b)* |  |
|  | *Estimated* Total 2019/2020 Scholarships/Tuition Discounts *(c)* |  |
|  | *Estimated* Remaining Need\* |  |
|  |  | | |
|  |  | | |

4. **NON-Federal Financial Aid Institutions need analysis:**

|  |  |
| --- | --- |
| Cost of Program for one Year |  |
| Tuition Discounts/Other Assistance *(do not include any type of loan)* |  |
| Students Responsibility for Cost of Program |  |

|  |  |
| --- | --- |
|  | Award for undergraduates is $2,000 annually. The Mary Marshall Nursing Scholarship Committee will not make an award that exceeds the “Remaining Need” in Question 3 or “Student Responsibility for Cost of Program” in Question 4. |

|  |  |  |
| --- | --- | --- |
| ***Please provide an original signature from Financial Aid office/authorized person.*** |  |  |
| Name of Financial Aid Officer/Authorized Person (Please Print) |  | Phone Number |
|  |  |  |
| Signature of Financial Aid Officer/Authorized Person |  | Date |
| E-Mail Address: |

**SECTION 10 – CERTIFICATION STATEMENT**

**I, the undersigned, hereby certify that all of the information on this scholarship application is true and complete to the best of my knowledge. I realize that information from this application will be used to determine scholarship eligibility. If asked by the Nursing Scholarship Advisory Committee, I agree to provide documentation verifying any information on this application. I have read and accept the conditions of the Mary Marshall Nursing Scholarship.**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Applicant |  | Date |

|  |
| --- |
| Full Name (Please Print) |

*Any persons dissatisfied with the award or denial of an application to become a scholarship participant must notify staff of the Nursing Scholarship Advisory Committee within 14 days of receiving notification of the award or denial of an application.*

For marketing purposes, how did you learn about this scholarship opportunity?

***Thank you for your interest in this program****!*

*Staff Record Only:  Application complete upon receipt  Additional information requested*