**VDH-OHE-Virginia’s Nurse Practitioner/Nurse Midwife**

**Scholarship Program 2019 APPLICATION**

**APPLICATION checklist 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.**

The Nurse Practitioner/ Nurse Midwife Scholarship Program provides scholarship awards to students who agree to practice full-time as a Nurse Practitioner or Nurse Midwife in a medically underserved area of Virginia. All awards are made by a Nursing Scholarship 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 Nursing Scholarship Committee and has no role in the determination of scholarship awarded to recipients. The guidelines for determining scholarship awards to recipients are established by the Nursing Scholarship Committee. Preference for the scholarship award shall be given to residents of the Commonwealth of Virginia who are minority students, students enrolled in Family Practice, Obstetrics,

Gynecology, Pediatrics, Adult Health, and Geriatric Nurse Practitioner Programs. Participants residing in Medically Underserved Areas (MUA’s) as determined by the Board of Health will also be given preference. In order to be considered for the Nurse Practitioner/Nurse Midwife Scholarship program, the following are required:

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 Virginia 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 6.) Ownership of real property 7.) Financial support records.

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 briefly explain the significance of the Virginia Nurse Practitioner/Nurse Midwife Scholarship in pursuing the applicant’s educational goals, any school/community activities, and any skill-set that is pertinent to the nursing profession. **If the Narrative Summary exceeds the one page limit, it will not be accepted**. Please include:

1. Scholastic attainment
2. Character attributes and adaptability to the nurse practitioner/nurse midwife profession
3. Plans for practicing in Virginia following graduation
4. Any specializations in the following areas: family practice, obstetrics and gynecology, pediatrics, adult health, and

geriatric nurse practitioner programs.

1. School and/or community activities
2. Any skill sets pertinent to the profession

Applicant must be accepted to or enrolled in a school of nursing in the State of Virginia which is approved by the State Board of Nursing. The applicant must have the Dean/Director/Chair of the Applicant’s School of Nursing complete **Section 8** of the application, 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 3.0 if currently enrolled in and attending a nursing program

**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.**

**Note:** Minority students are defined as students of one or more of the following federally recognized minority populations: African American/Black, Hispanic/Latino, Asian, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native. Medically Underserved Areas (MUA’s) can be located at <http://www.vdh.virginia.gov/OHE/primarycare/shortagedesignations/index.htm> or by contacting Olivette Burroughs at 804-864-7431.

**SECTION 1 – PERSONAL DATA**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please Select One: Nurse Practitioner  Nurse Midwife  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 live in a Medically Underserved Area? | | | | |  | | | | | | | | | | | |
| What is your Congressional District: | | | | | (Please check with your voter registration office or visit http://nationalatlas.gov/printable/congress.html) | | | | | | | | | | | |
| Do you have an active military service obligation? | | | | |  | | | | | | | | | | | |
| Are you a high school graduate? | | | | | | | Do you possess a GED? | | | | | | | | | |
| Have you ever received a Nurse Practitioner/Nurse Midwife 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**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Current Graduate 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 Specialty | Current Level | Level in September |
|  |  |  |

**SECTION 3 – PRIOR EDUCATION**

*Please check all that you have successfully obtained:*

CNA LPN  ASN  BSN  Other:

Current License:      Current License Number:

Please provide the following information:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | School and Program | Diploma/Degree/Certificate | City and State | Dates of Attendance | Reason for Leaving |
| 1. |  |  |  | to |  |
| 2. |  |  |  | to |  |
| 3. |  |  |  | to |  |
| 4. |  |  |  | to |  |
| 5. |  |  |  | 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 – OTHER FINANCIAL ASSISTANCE (including other scholarships and grants)**

Are you receiving any other type of financial assistance for the upcoming school year?

**Please indicate:**

**SECTION 7 – NARRATIVE SUMMARY (Required on an attached sheet)**

Briefly explain, *in one page or less*, the significance of the Virginia Nurse Practitioner/Nurse Midwife Scholarship Program in pursuing your educational goals. Be sure to include your scholastic attainment, character, and adaptability to the nurse practitioner/nurse midwife profession if applicable. It is important to mention plans for practicing in Virginia following graduation and any specializations in the following areas: family practice, obstetrics and gynecology, pediatrics, adult health, and geriatric nurse practitioner programs. Also, include school and/or community activities as well as any skill-set that is pertinent to your profession.

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 RECOMMENDATION**

***To be completed by the Dean/Director of the School of Nursing***

1. Name of applicant:      ­­­
2. Student Identification or Social Security Number:
3. This applicant is:
4. State Date: Month       Year
5. During this award period, the applicant will be a:
6. *If the student is currently enrolled in your Nursing Program, please select one of the following:*
7. *If student is currently enrolled in your Nursing Program, please provide a cumulative GPA of current nursing courses. Applicants must have at least a 2.5 cumulative GPA in Required Nursing Courses, electives should not be considered in the Cumulative*

GPA: List GPA

Source of computing GPA:  If other, please specify:

Please provide a brief recommendation (in 1,600 characters or less) regarding the student based on the student’s scholastic attainment, character, need, adaptability, and/or other attributes. Please mention any progress in the following areas of specializations: family practice, obstetrics and gynecology, pediatrics, adult health, and geriatric nurse practitioner programs.

***Please provide an original signature from authorized personnel.***

|  |  |  |
| --- | --- | --- |
| I recommend |  | for a Nurse Practitioner/Nurse Midwife Scholarship Award. |

*Full Name of Applicant*

|  |  |  |
| --- | --- | --- |
|  |  |  |
| 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 RECOMMENDATION**

**This section is to be completed and signed by the Financial Aid Officer, Program Director or Authorized Personnel of your institution.**

The Virginia Nurse Practitioner/Nurse Midwife Scholarship Program and the Nursing Scholarship Advisory Committee recommends its awards to the State Health Commissioner based on the financial need of an applicant. Financial Need is one of the many determining factors for award; however, **it is not required for eligibility of the program**. Please use the applicant’s current needs analysis to recommend the amount of scholarship required, after taking into consideration other financial aid the applicant is receiving.

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **3.** | **Student Costs and Resources:** | | | |
|  | Student Aid Budget for Applicant |  | | |
|  | Expected Family Contribution (EFC) |  | | |
|  | Financial Aid Received (excluding loans) |  | | |
|  | Remaining Need |  | | |
|  | Cost of Program for One Year (including tuition, fees, books, uniforms, etc.) |  | | |
|  |  | |  | | |
| **4.** | **Scholarship Recommendation:** | | | | |
|  | The Nursing Scholarship Committee reviews and makes recommendations on the scholarship award annually, as funding allows. The award range for a graduate applicant varies depending on the number of applicants and the Appropriation by the Virginia General Assembly. The commissioner approves awards. | | | | |
|  |  | | |  | |
|  | After careful  review of the applicant’s financial situation,  I  recommend a Nurse Practitioner/Nurse Midwife Scholarship award of (*check one*): | | | $5,000 to $9,999 annually | |
|  | $10,000 to $14,999 annually | |
|  |  | | | $15,000 and up annually | |

1. If your recommendation is less than both the "remaining need"  and the “maximum allowable” reflected  above, please explain:

* 1. Needs Analysis Method Used:

Please indicate which of the following methods was used to determine the applicant's financial need and the academic year that the applicant is requesting assistance. (Financial Aid Officers are encouraged to use the need analysis for the year in which the student is applying for assistance.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| CSS | ACT | PELL | FAFSA | Academic Year :  2019 to 2020 |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Name of Financial Aid Officer/Authorized Personnel (Please Print) |  | Phone Number |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Financial Aid Officer/Authorized Personnel |  | Date |

|  |
| --- |
|  |
| E-Mail Address |

**SECTION 10 – COMMITMENT OF SERVICE**

**Do you plan to seek employment in an area officially designated as a Medically Underserved Area (MUA)?**

**Do you plan to seek employment and serve in an employment setting that provides services to persons who are unable to pay for the service and participates in all government sponsored insurance programs designated to assure access to medical care services for covered persons?**

**SECTION 11 – 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 Virginia Nurse Practitioner/Nurse Midwife Scholarship Program.**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| 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*