

ARKANSAS NURSES FOUNDATION (ArNF) SCHOLARSHIP FORM

Name _____ Date _____
 Home Address _____
 City _____ State _____ Zip _____
 Daytime Phone _____ Cell/Pager _____ Fax _____
 Email _____

EDUCATIONAL PREPARATION (all nursing programs attended)

Name & Location of School of Nursing	Years Attended		LPN/AD/Diploma/BSN
	To	From	

Degrees obtained (if different from above): _____ Date(s) _____

Program planning to attend for which you are seeking scholarship _____
 (To qualify for the scholarship, this must be a NLNAC or CCNE accredited institution)

Date of acceptance into the program _____ (attach copy of letter of acceptance)

REFERENCES (list names, addresses, daytime telephone, and email, of individuals who submitted a reference letter for you.)

1.	2.

See Arkansas Nurses Foundation Scholarship Policies for additional information and materials required.

I have read the requirements concerning the granting of this scholarship, and I agree to abide by the stipulations.

 Signature Printed name Date

The amounts of scholarship awards vary and are awarded at the discretion of the ArNF officers. Scholarships are awarded without regard to race, sex, religion, age, sexual orientation, or national origin. The ArNF reserves the right not to award a scholarship if applicants are not considered qualified. Scholarships are awarded for one year only.