COLUMBUS BLACK NURSES ASSOCIATION Email to: <u>cbna.ohio@gmail.com</u> 614-470-2526



APPLICATION FOR SCHOLARSHIP

Name				
First	Middle		Last	
Address				
City	State		Zip	
Phone No Wo	rk No		_Cell No	
E-mail				
Do you currently hold a Nursing License? Yo	es <u>No</u>	If Yes Licens	e Number	
Did you have another profession that held a Degree or Certification before pursuing your Nursing Career? Yes No If yes what was it?				
Are you a Student Nurse? YesNo What Year?				
Are you presently enrolled in an Undergrad Nursing Program? YesNo				
Are you presently enrolled in a Graduate Program? Yes No				
Current School or College of Nursing Enrollment:				
Name				
Address				
City	State_		Z	/ip
Dean/Director		_School Phone	e No	
Expected Graduation Date				
Are you a member of the Columbus Black Nu	irses Association?	Yes	_No	
I hereby affirm that all the information provided is true. Any false statements in this application will forfeit the scholarship award.				