

The Kent County, Kalamazoo-Muskegon Black Nurses Association (KMMBNA)

SCHOLARSHIP APPLICATION FORM

Please: Type or Print in Ink. Your data MUST be legible and easily interpreted.

PERSONAL DATA:

Name: _____

First _____ Middle _____ Last _____
Home Phone # _____ Work # _____

Fax # _____ Email _____ Cell # _____

Current mailing Address: City _____ State _____ Zip _____

Date of Birth: _____ Social Security No. _____

Applicant's Place of Employment: _____

Applicant's Employer Address: _____ Spouse's Name if applicable _____

HEAD OF HOUSEHOLD: Father _____ Mother _____ Self _____ Spouse /Other _____

OTHERS YOU SUPPORT: Name _____ Relationship _____

Age _____ Place of Employment of Spouse / Other if Applicable _____

LICENSE:

Do you currently hold a Nursing License? RN, LPN/LVN) YES__ NO__ If Yes, License Number _____
State _____ Anticipate Source of Income, i.e., Work, Family, Scholarship, Grant, Loans, Veterans Benefits,
Etc. List: _____

CURRENT SCHOOL OF NURSING ENROLLMENT: *If you obtained your generic nursing education from another school, also list your generic school of Nursing:*

Generic School of Nursing _____

Name (current school): _____

Address: _____

City _____ State _____ Zip Code _____

Current Dean/Director _____ School Phone No. () _____

What level (1st year, etc.) _____ Expected Graduation Date _____

Advisor _____ Most Recent Grade Point Average (CGPA) _____ Date _____

EXTRACURRICULAR / VOLUNTEER COMMUNITY ACTIVITIES (List)

MEMBERSHIP: KMMBNA Member Renewal? YES _____ NO _____ (Do not send dues if you are a student without a nursing license) KMMBNA Student Member? YES _____ NO _____
Chapter if Applicable _____

I hereby affirm that all the information provided is true. Any false statement will forfeit the award. DEADLINE for receipt of application is Friday, April 21, 2017 (Post Office date, no metered mail). NO E-MAILS!!!!

ENDORSEMENT: Attach ESSAY of 100 words on "Why you chose to pursue a career in Nursing, or contribution to the Field of Nursing if already a scholarship recipient?"

SIGNATURE _____ DATE _____

(My signature confirms that I have read the guidelines and agree to adhere, otherwise I accept the fact that the scholarship will not be awarded). You may attach a continuation sheet if necessary.

Submit to:

Shahidah El-Amin, HHP, BS, RN
Scholarship Selection Committee Chairperson
2745 Birchcrest Dr. S.E. Ste 807
Grand Rapids, MI 49516-6001

(UPDATED 1-5-2017)

