

Associate Degree Nursing Scholarship Application



Postmark Deadline: September 11, 2011

Application materials postmarked after the deadline will not be reviewed.

Faxed copies will not be accepted.



Giving Golden Opportunities by:

Awarding nurses who are dedicated to practicing in underserved communities.

Improving access to healthcare in rural and urban areas of California.

ADN Application Instructions

NOTE: This application is designed to be printed and filled in manually. To download the application you must have Adobe Reader. Go to www.adobe.com for a free copy of Adobe Reader.

The purpose of the Associate Degree Nursing Scholarship Program (ADNSP) is to increase the number of registered nurses (RN) practicing in medically underserved areas of California. If awarded, the applicant agrees to provide direct patient care on a full time basis (40 hours per week or its equivalent) in a designated shortage area for a minimum of two (2) years.

Applications for the Associate Degree Nursing Scholarship Program are accepted annually and award up to **\$10,000**. Scholarships are intended to pay tuition, required fees, books, supplies, and educational equipment costs related to the applicant's registered nurse education.

The ADNSP is administered by the Health Professions Education Foundation (Foundation) and is funded by a \$10.00 surcharge on each Registered Nurse licensure renewal. All awards are subject to the availability of funding.



AM I ELIGIBLE?

To be eligible for the Associate Degree Nursing Scholarship, the applicant must:

- be currently accepted or enrolled in an Associate Degree nursing program in California
- be free from any other service obligation
- have valid legal presence and ability to work and provide care in the state of California
- submit a complete application that is postmarked on or before September 11, 2011

HOW DO I APPLY FOR A SCHOLARSHIP?

For your application to be considered eligible for the ADNSP, each of the items listed below must be sent in and filled out completely. ALL MATERIALS MUST BE POSTMARKED BY THE DEADLINE OF SEPTEMBER 11, 2011.

It is highly recommended that applicants submit their applications before the postmark deadline. The Foundation will not notify applicants if their application is received incomplete. No documentation of any kind will be accepted by fax or email.

1. Completed Application

Complete all entries and pages of this application. It must be completed, signed and dated to be considered eligible.

2. Official Transcript

The transcript must be marked "official" by the school. The Foundation will not accept unofficial transcripts, copies or print outs of transcripts, or transcripts in an open/unsealed envelope. Applicant must submit all post high school transcripts.

3. Personal Statement (Part E of the Application)

Attach the personal statement to the application. Your statement must be typed and no more than (2) pages. Restate and number each question along with your answer.

Statements must provide a comprehensive response to each question. Personal Statements that lack detail may be considered incomplete and therefore, ineligible.

4. Two Professional Letters of Recommendation

Letters of recommendation must be dated within six (6) months of the application deadline (between March 2011 and September 2011). The letters must be on letterhead or include the author's title, name of employer, mailing address, and phone number. It is recommended that at least one letter be from a faculty member.

5. Employment History

Please list up to four employers that are health related.

6. Graduation Date Verification (GDV)

This form must be signed by the program director or an appropriate designee. The GDV is enclosed as part of this application.

7. Signed 2010 Federal Tax Return and all W-2's and/or 1099 or Student Aid Report (SAR)

DO NOT SUBMIT A STATE TAX RETURN. The State Tax Return will not be accepted in lieu of the Federal Tax Return.

WHAT IS THE SELECTION CRITERIA?

Awards are made on a competitive basis. Selection for the ADNSP is based solely on information contained in the application and supporting documentation. Only complete applications will be evaluated.

Priority will be given to applicants whose background and commitment indicates the likelihood of long-term employment in a MUA even after the service obligation has ended. Students who will graduate within one year will also be given priority.

Selection for awards is based on the following criteria:

- **Cultural and Linguistic Competence** – the applicant's ability to understand and respond effectively to the cultural and linguistic needs of patients.
- **Financial Need** - actual or potential difficulty in paying educational debt in the absence of an award.
- **Career Goals** - professional goals for the next five (5) to ten (10) years.
- **Community Service** - documented volunteer service and/or activities, particularly in a MUA.
- **Background** - family structure, socioeconomic background and community where applicant grew up; for example, rural, inner city/urban, suburban, or MUA.
- **Fluency** - Although it is not a requirement to speak a second language, fluency in a language other than English must be verified by the nursing program director on the Graduation Date Verification (GDV) Form.

WHEN WILL I FIND OUT IF I HAVE BEEN AWARDED?

The Foundation will notify applicants of their application results within **120 days** of the postmark deadline (January 9, 2012) via email and regular mail.

ADN Application Reference

Glossary of Terms

Direct Patient Care: the provision of health care services directly to individuals being treated for, or suspected of having physical or mental illnesses. Direct patient care includes preventive care and first line supervision.

Economically Disadvantaged: a person whose gross family income at the time of application and the immediately preceding 2 years fell below 150 percent of the federally recognized poverty level.

Full Time Student: a student who is enrolled in a semester, trimester or quarter program of not less than 12 credit hours or units or their equivalent.

Health Professional Shortage Area (HPSA): a medically underserved area.

Medically Underserved Area (MUA): means any of the following:

- a. A Medically Underserved Area or Medically Underserved Population (MUA or MUP) as designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions' Shortage Designation Branch.
- b. A Primary Care Health Professional Shortage Area (HPSA) as designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions' Shortage Designation Branch.
- c. A California Primary Care Shortage Area as designated by the California Healthcare Workforce Policy Commission.
- d. A facility determined by the Director pursuant to section 128385 of the Health and Safety Code to be an eligible county health facility or an eligible state-operated health facility.

Scholarship: financial assistance provided to an eligible individual who agrees, in return for the assistance, to practice his or her profession for a specified period of time in a medically underserved area of the state.

Service Obligation: the contractual obligation agreed to by the recipient of a scholarship where the recipient agrees to practice their profession for a specified period of time in or through a designated facility.

Frequently Asked Questions

GENERAL

1. **Do I have to be a permanent California resident and U.S. citizen to apply for the ADN scholarship?** You must be have legal permanent residency in California to apply for all programs administered by the Health Professions Education Foundation. We do not require that you be a U.S. citizen.
2. **How many applicants are awarded each cycle through the ADN?** The number of applicants awarded each cycle depends on the number of eligible ADN applications received as well as the availability of funding. Each cycle is unique and the Foundation staff cannot predict the number of award recipients.
3. **How is the ADN scholarship funded?** A ten dollar (\$10) surcharge is collected by the Board of Register Nurse at the time of initial licensure and renewal. These funds support the Associate Degree and Bachelor of Science Nursing Scholarship programs and the Bachelor Science Loan Repayment Program.

APPLYING FOR THE SCHOLARSHIP

4. **When is the deadline to turn in an application?** The annual postmark for the ADN is September 11. Make sure that the application you are using reflects the most current year. Updated applications are posted on our web site annually.
5. **Can I submit my application prior to the postmark deadlines?** You are encouraged to submit your ADN application prior to the postmark deadline in order for Foundation staff to verify that your packet is complete. Any documents submitted beyond the postmark deadline will not be accepted.
6. **May I request an extension to file my application if I cannot obtain all the required documents by the postmark deadline?** No. All documents must be postmarked by the application due date. No exceptions.
7. **Can my letters of recommendation be sent directly to the Foundation or do I need to include them with my ADN application?** You can either have your letters of recommendation sent directly to our office or you can submit them along with your application packet. However, it is the applicant's responsibility to ensure that all documents are postmarked by the cycle deadline.

ADN Application Reference

Frequently Asked Questions Continued

8. What is the maximum award amount for the ADN and am I guaranteed to receive this full amount? The maximum award amount for the ADN is up to \$10,000 for scholarships. Award recipients may not receive the full amount.

ELIGIBILITY

9. Who is eligible for an ADN scholarship? Scholarships are available to students who are enrolled or accepted in an accredited associate degree nursing program. Priority will be given to students who will graduate within one year.

10. Can I still apply for the ADN if I currently owe an existing service obligation? If you owe an existing service obligation to another entity, you are ineligible to apply with the Foundation until you have completed your existing obligation.

11. Can I apply for a Foundation scholarship if I attend school outside of California? No. You must be a California resident attending a California accredited college or University in order to receive a scholarship or loan repayment award from the Foundation.

12. Do I have to be bilingual in order to apply for the scholarship? No. You do not have to be bilingual in order to apply for the scholarship.

AFTER I'VE SUBMITTED MY APPLICATION

13. When will I be notified whether or not I have been selected to receive an award? The Foundation will notify applicants of their ADN results within 120 days of the final filing date.

14. If I am selected to be a scholarship recipient for the scholarship, does the money come directly to me or will it be sent to my school? Checks will be issued directly to the school on the recipient's behalf.

15. If I am selected to be a scholarship recipient for the ADN, how many times can I reapply? ADN recipients may apply once per academic year for up to two awards from the Health Professions Education Foundation. However, there is no limit as to the number of times someone can apply. Note: Scholarship recipients may be awarded up to two (2) times which requires a two-year service obligation for each contract.

16. If I receive a scholarship, is it likely I will receive a subsequent scholarship? Being a current recipient does not increase or decrease your likelihood to receive a subsequent scholarship.

17. If I am NOT selected to be a scholarship recipient of the ADN and I reapply again, do I need to resubmit my entire application or can you reuse the materials I have already submitted? ADN applicants must resubmit a complete application packet each time they apply. The Health Professions Education Foundation will not reuse or send back any documentation previously submitted.

SIGNING A CONTRACT

18. If I am selected to be a scholarship recipient of the ADN, what are the terms of my contractual obligation? All ADN award recipients are required to complete a two-year service obligation in a qualified facility providing a minimum of 40 hours a week (or its equivalent) direct patient care.

19. How do I determine which facility qualifies as a medically underserved area (MUA) or Health Professional Shortage Area? All county, state, VA, or prison facilities automatically qualify. Visit the Foundation's web site at www.healthprofessions.ca.gov and click the "MUA" on the menu bar. You will be asked to enter the address of the facility you wish to identify as a MUA or HPSA.

20. What happens if I am unable to fulfill the terms of my contractual obligation and cannot complete my service obligation? If an award recipient is unable to fulfill their contractual obligation, they will be required to repay all scholarship funds received, plus ten percent (10%) interest.

21. What happens if I need to change jobs during my service obligation? You have the option to change jobs during the term of your service obligation. However, in order to comply with the terms of your contract, you must remain employed with a qualified facility.

For additional information on how to complete this application, please visit the Foundation's web site at www.healthprofessions.ca.gov to access a Power Point presentation and for dates of technical assistance calls.



Please do not staple any portion of the application. This page must be completed and submitted for your application to be considered complete. Faxes will not be accepted.

ADN Scholarship Application

Please enter the amount you are requesting (up to \$10,000):

Please refer to the application instructions when completing the application. Complete all pages of the application and make sure all supporting documents are submitted with your application. All documents must be postmarked by the application deadline of SEPTEMBER 11, 2011. Late or incomplete application packets will not be evaluated. Copies of pages requiring original ink signatures will not be accepted.

PART A PERSONAL INFORMATION (Download and save this document to your computer.)

All personal and identifying information provided will remain private and confidential and will not be disclosed outside the ADN SP award process.

Driver License or ID #: _____

*Social Security #: _____

Mr.

Mrs.

Ms.

First Name: _____

Middle Initial: _____

Last Name: _____

Mailing Address

Street: _____

City: _____ State: CA Zip: _____

County: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____ Re-enter email address: _____

Date of Birth: (mm/dd/yyyy) _____

Male

Female

Marital Status: (Optional) _____

No. of Dependents: _____

Do you have valid legal presence in the U.S.? Yes

No

Will you be providing direct patient care in CA? Yes

No

Racial/Ethnicity: (Please choose one) Collected for statistical purposes only.

African American/Black

Asian American

White/Caucasian

Hispanic/Latino

Pacific Islander

Native American

Other (please specify)



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Last Name: _____

First Name: _____

PART B – QUESTIONNAIRE

Do you currently owe an existing service obligation to another entity?

Yes No

Please note: If you answer yes to this question, you do not qualify for this scholarship.

Are you currently a military veteran? If so, please provide proof of honorable discharge.

Yes No

Are you a prior awardee of the Foundation? If yes, please enter the contract #

Yes No

Are you the first in your family to attend college?

Yes No

How did you hear about the Associate Degree Nursing Scholarship Program? (Check all that apply)

<input type="checkbox"/> School	<input type="checkbox"/> Newspaper or Publication (please specify below)
<input type="checkbox"/> Work	_____
<input type="checkbox"/> Friend/acquaintance	<input type="checkbox"/> Organization or Affiliation (please specify below)
<input type="checkbox"/> TV	_____
<input type="checkbox"/> Radio	<input type="checkbox"/> Conference (please specify below)
<input type="checkbox"/> Foundation Web site	_____
<input type="checkbox"/> Advertisement	<input type="checkbox"/> Other Web site (please specify below)
<input type="checkbox"/> Other Source	_____

Where did you receive the Associate Degree Nursing Scholarship Program application? (Check only one)

Program Director

Foundation Office

Foundation Web site

Other Web site

Work

Friend/Acquaintance

Other

PART C - LINGUISTIC COMPETENCY

1. List any languages in which you are fluent. This must be verified by your employer on the Graduation Date Verification form.

1st Language: _____

2nd Language: _____

PART D - LVN APPLICANT (only LVN to ADN applicants)

If you are a licensed Vocational Nurse and you are not awarded by the ADN program, your application may be automatically considered eligible for the LVN to ADN program.

Yes, please submit this application to the LVN to ADN program.

No, please do not submit this application to the LVN to ADN program.



Please do not staple any portion of the application. This page must be completed and submitted for your application to be considered complete. Faxes will not be accepted.

Last Name: _____

First Name: _____

PART E - PERSONAL STATEMENT

Attach your personal statement to the application. Your statement must be typed and no more than two (2) pages. Restate and number each question along with your answer. Personal statements that lack detail may be considered incomplete and therefore ineligible.

1. Describe your family background including your parent or guardian's occupation, marital status, family size such as number of dependents including yourself, where you were raised, first in family to attend college, English as a second language or any other factors that help describe your family's socioeconomic situation and how your background relates to your interest pursuing a nursing career.
2. Describe your short term and long term career goals as it relates to providing direct patient care in a medically underserved area.
3. Illustrate your experience as it pertains to living in an economically disadvantaged background.
4. Describe any community service, volunteer activities, or club memberships that you have been involved in within the past two (2) years including the number of hours worked. (Please provide a letter or documentation of your involvement including contact information for the organization: name, address and phone number. Do not include experience for which you received academic credit.)
5. Please tell us your reasons for applying for this scholarship.



**HEALTH PROFESSIONS
EDUCATION FOUNDATION**

Giving Golden Opportunities



Please do not staple any portion of the application. This page must be completed and submitted for your application to be considered complete. Original ink signature required. Copies and faxes will not be accepted.

Last Name: _____

First Name: _____

Graduation Date Verification Form

ATTENTION! The completed form must bear an original ink signature. Photocopies and faxed copies of the completed form are not acceptable. THIS FORM IS TO BE COMPLETED BY THE PROGRAM DIRECTOR OR AN APPROPRIATE DESIGNEE. The person signing this form may not be related to the applicant by blood, marriage, or adoption. All entries on this form must be filled out to be considered complete.

Applicant's Last Name: _____ First Name: _____ MI: _____

School Name: _____

Program Enrolled: _____

School Mailing Address: _____

City: _____ State: CA Zip: _____ County: _____

Date program started: _____ Expected Graduation Date: _____

Enrollment Status: F/T or P/T

of Units currently enrolled: _____ or # of units equivalent if on a modular system: _____

Please comment on the student's performance and potential for academic success.

1. I verify that the applicant can speak the following language(s):

1st Language: _____

2nd language: _____

2. I declare under penalty of perjury that these statements are true and correct to the best of my knowledge.

Name: (Please Print) _____

Signature: _____

Title: _____

Phone/Ext: _____ X _____

Fax: _____

Email: _____

Date: _____

Tape Business Card On All Four Corners
DO NOT STAPLE
BUSINESS CARD REQUIRED

no business card available



If this page is not SIGNED and DATED by the Program Director or an appropriate designee, the application will be considered INCOMPLETE and INELIGIBLE. Send this ORIGINAL SIGNED AND DATED PAGE to the Foundation postmarked no later than September 11, 2011. No copies or faxes will be accepted.



Please do not staple any portion of the application. This page must be completed and submitted for your application to be considered complete. Faxes will not be accepted.

Last Name: _____

First Name: _____

Employment History

Please list any work experience that is health related. **List most recent employer first (maximum of 4 employers)**. All entries must be filled to be considered complete.

Employer's Name: _____

Street Address: _____

City: _____

State: _____ Zip: _____

County: _____

Supervisor's Name: _____

Telephone Number: _____

Email: _____

Start Date: _____

End Date: _____ OR PRESENT

Your Position/Title: _____

Full-time Part-time Per Diem Volunteer

Brief Description of your job duties: _____

Employer's Name: _____

Street Address: _____

City: _____

State: _____ Zip: _____

County: _____

Supervisor's Name: _____

Telephone Number: _____

Email: _____

Start Date: _____

End Date: _____ OR PRESENT

Your Position/Title: _____

Full-time Part-time Per Diem Volunteer

Brief Description of your job duties: _____

Employer's Name: _____

Street Address: _____

City: _____

State: _____ Zip: _____

County: _____

Supervisor's Name: _____

Telephone Number: _____

Email: _____

Start Date: _____

End Date: _____ OR PRESENT

Your Position/Title: _____

Full-time Part-time Per Diem Volunteer

Brief Description of your job duties: _____

Employer's Name: _____

Street Address: _____

City: _____

State: _____ Zip: _____

County: _____

Supervisor's Name: _____

Telephone Number: _____

Email: _____

Start Date: _____

End Date: _____ OR PRESENT

Your Position/Title: _____

Full-time Part-time Per Diem Volunteer

Brief Description of your job duties: _____



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Last Name: _____

First Name: _____

PART F – TWO LETTERS OF RECOMMENDATION

Must be **dated** and **signed** within the last **six (6) months** of the deadline date (March - September 2011). Must be on letterhead or include the author’s title, name of employer, mailing address, and phone number. If any of these items are missing from the letter, it will be deemed incomplete and therefore, ineligible.

- Please check one: My two letters of recommendation comply with the instructions above and are included in my packet.
- My two letters of recommendation comply with the instructions above and will be sent separately to ADN Scholarship Program, 400 R Street, Suite 460, Sacramento, CA 95811 by the postmark deadline of Sept. 11, 2011.

PART G – OFFICIAL TRANSCRIPTS

Must be sealed and marked “Official” by the school(s). Electronic submission must be sent from the school directly to the Foundation e-mail account: hpef-email@oshpd.ca.gov. If applicant has attended multiple colleges, all official transcripts must be submitted.

- Please check one: My official transcripts comply with the instructions above and are included in my packet.
- My official transcripts comply with the instructions above and will be sent separately to ADN Scholarship Program, 400 R Street, Suite 460, Sacramento, CA 95811, by the postmark deadline of Sept. 11, 2011.
- My official transcripts comply with the instructions above and will be emailed to the Foundation's email at hpef-email@oshpd.ca.gov.

PART H – 2010 TAX RETURN AND ALL W-2’S OR STUDENT AID REPORT

2010 Federal Tax Return only (1040, 1040EZ, etc.). Your **signature** must appear on the tax return regardless of who prepared it or how it was filed. If included on parents’ tax statements, please submit those tax returns. Include all W-2’s or proof of income (1099). If joint return filed, include both parties’ W-2’s and/or 1099. If self-employed, check this box (Tax Return are still required.) If you or joint party do not have W-2’s, check this box and provide an explanation:

Or SAR 2010-2011 or 2011-2012 Report Only

Must be official copy showing the expected family contribution (EFC) from college financial aid office, Federal Student Aid or from the Internet at <http://www.fafsa.ed.gov/faq016.htm>. Do not submit FAFSA documents.

- Please check one: My signed 2010 Federal Tax returns and W-2’s comply with the instructions above and are included in my application packet.
- My signed 2010 Federal Tax returns and W-2’s and/or 1099 comply with the instructions above and will be sent separately to ADN Scholarship Program, 400 R Street, Suite 460, Sacramento, CA 95811, by the postmark deadline of Sept. 11, 2011.
- My 2010-2011 or 2011-2012 Student Aid Report comply with the instructions above and are included in my application packet.
- My 2010-2011 or 2011-2012 Student Aid Report comply with the instructions above and will be sent separately to ADN Scholarship Program, 400 R Street, Suite 460, Sacramento, CA 95811, by the postmark deadline of Sept. 11, 2011.

PART I – COST OF ATTENDANCE/TUITION

Must be included in the application package. Any missing information will deem your application incomplete and/or ineligible.

- Check when completed: I have included the cost of attendance with my application packet.



Please do not staple any portion of the application. This page must be completed and submitted for your application to be considered complete. Faxes will not be accepted.

Last Name: _____

First Name: _____

PART J – CONTACTS

List names, relationship, address, telephone numbers and emails of three (3) persons not living with you -- preferably relatives-- that will know how to reach you should the Foundation need to contact you immediately.

CONTACT 1

Name _____

Relationship to applicant _____

Mailing Address _____

Phone _____

Email _____

CONTACT 2

Name _____

Relationship to applicant _____

Mailing Address _____

Phone _____

Email _____

CONTACT 3

Name _____

Relationship to applicant _____

Mailing Address _____

Phone _____

Email _____

PERSONAL INFORMATION NOTIFICATION The Information Practices Act of 1977 and the Federal Privacy Act require this program to provide the following to individuals who are asked by the Office of Statewide Health Planning and Development, Health Professions Education Foundation to supply information: The principal purposes for requesting personal information are for verification of identification, establishment of eligibility and program administration. Program regulations (Chapter 14 of Title 22 of the California Code of Regulations, Sections 97701 et seq.) require every individual to furnish appropriate information for application to the Associate Degree Nursing Scholarship Program. All requested information is required unless it is specifically identified as voluntary. Failure to furnish this information may result in the return of the application as incomplete. An individual has a right of access to records containing his/her personal information that are maintained by the Office of Statewide Health Planning and Development, Health Professions Education Foundation. The person responsible for maintaining the information is the Executive Director, Health Professions Education Foundation, 400 R Street, Suite 460, Sacramento, CA 95811, (916) 326-3640. The Foundation may charge a small fee to cover the cost of duplicating this information.

***MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS**

Disclosure of your U.S. Social Security Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application will not be processed AND you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.



Please do not staple any portion of the application. This page must be completed and submitted for your application to be considered complete. Original ink signature required. Copies and faxes will not be accepted.

Last Name: _____

First Name: _____

PART K – INFORMATION RELEASE

I, the undersigned, authorize staff of the Office of Statewide Health Planning and Development/Health Professions Education Foundation (OSHPD/Foundation), to verify completion of my degree in connection with the Associate Degree Nursing Program if I am awarded. I understand that the information to be provided will include information regarding my academic performance and/or graduation date (month and year). I also authorize staff to verify my employment in connection with the Associate Degree Nursing Program if I am awarded. I understand that the information to be provided will include my employment history and position status. Any information obtained through this release is to be kept confidential by the OSHPD/Foundation. This authorization is valid for five (5) years from the date of this form.

PART L – APPLICATION CERTIFICATION

I certify that all information in this application is true and accurate to the best of my knowledge. I authorize the Health Professions Education Foundation (Foundation) to verify any information submitted as part of this application. I understand that falsification of information contained in this application will disqualify my application and that the California Board of Registered Nursing will be notified. I understand that if falsification is discovered after I have been awarded or if I breach my contract, I will be required to repay all funds awarded, plus interest and administrative fees. I understand that once submitted, my application and supporting documents become the property of the Foundation. I also understand that my personal statement becomes the property of the Foundation and may be used, including but not limited to, advertising/marketing, program reports, newsletters, and other publications.

Last Name: _____ First Name: _____ MI: _____

Applicant's Signature: _____ Date: _____



If you do not SIGN and DATE your application, it will be considered INCOMPLETE and INELIGIBLE. Send this ORIGINAL SIGNED AND DATED PAGE. Electronic signatures are NOT acceptable. No copies or faxes will be accepted.



PART M: APPLICATION SUBMISSION DEADLINE IS SUNDAY, SEPTEMBER 11, 2011

Application & Document Checklist

- Application pages 1 - 8
- Personal Statement (2 pages, typed)
- Employment History
- Graduation Date Verification
- Two Letters of Recommendation
- Official Transcripts
- 2010 Federal Tax Return and W-2's or Student Aid Report
- Cost of Attendance/Tuition
- Signatures on pages 4 and 8

Submit applications to:
Health Professions Education Foundation
ATTN: ADN Scholarship Program
400 R Street, Suite 460
Sacramento, CA 95811
(800) 773-1669 or (916) 326-3640

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HEALTH PROFESSIONS EDUCATION FOUNDATION

Giving Golden Opportunities

400 R Street, Suite 460
Sacramento, CA 95814
www.healthprofessions.ca.gov
(800)773-1669

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