UNIVERSITY OF ROCHESTER SCHOOL OF NURSING

SCHOLARSHIP & GRANT FUNDING REQUEST & RECERTIFICATION

Applicant Name: _____**Student Number**: _____

Program: ☐ RN-BS ☐ RN-BS-MS ☐ Masters (specify) _____ ☐ Leadership (specify) _____ ☐ DNP

Scholarship Program: ☐ FLRS ☐ OMH ☐ Bassett ☐ DNP Practice Fellows ☐ SON Tuition Grant

☐ Affiliate Professional Development Grant ☐ Emerging Leaders (MNE, CNL, HCM)

☐ Other _____

Home Address: _____

City: _____ **State:**_____ **County:**_____ **Zip Code:** _____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Current email address: _____

Are you currently employed? ☐ Yes, Employer _____ ☐ No

Position: _____**Employment Status:** ☐ Full time ☐ Part time ☐ Per Diem

Anticipated yearly financial support for Education (indicate amounts for all that apply):

☐ Employment tuition benefits $_____ or _____% ☐ Student Loans $_____

☐ Scholarships $_____ ☐ Other $_____

Complete the information below for courses you are enrolled in this semester:

☐ **Fall** ☐ **Spring** ☐ **Summer** **20** _____

	Course#*	Course Title	# Credit Hours
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Scholarships have been funded by the generosity of School of Nursing donors. Scholarships will be awarded each semester based on course registration and available funding. You will receive written notification of the status of your application within five to ten business days from receipt of all completed requested documents.

I acknowledge that the URSON scholarship will be used in addition to employer tuition benefits and the combination of the two will not exceed the full cost of tuition. I am aware that this scholarship may impact financial aid packages, including loan amounts. I also understand that I may be contacted by the Alumni Relations Office to meet with the donor of my scholarship and/or to provide biographical information to the donor. I understand that any changes in course registration must be reported to the Sr. Financial Analyst. I certify that the information contained in this application is true and correct to the best of my knowledge.

I authorize the Registrar/Bursar to release grade information to my employer as a condition of receiving tuition reimbursement. I understand it is the employer's decision to continue funding pending receipt of this information.

_____ _____

SIGNATURE OF APPLICANT DATE

Please return completed forms to: School of Nursing Scholarships
601 Elmwood Avenue, Box SON, Rochester, NY 14642
Phone: 585-276-6079 Fax: 585-276-2551
SON_Scholarships@urmc.rochester.edu