

CRAVEN COMMUNITY COLLEGE
Student Nurse Association
SCHOLARSHIP APPLICATION

PLEASE PRINT OR TYPE.

FULL NAME:

LAST FIRST MIDDLE MAIDEN

PRESENT ADDRESS:

PO BOX STREET CITY STATE ZIP CODE

TELEPHONE: HOME _____ CELL _____ WORK _____

STUDENT ID # _____ SOCIAL SECURITY # (Last 4) _____

SEX _____ RACE _____ DATE OF BIRTH _____

US CITIZEN: YES _____ NO _____ COUNTY OF LEGAL RESIDENCE _____

CHECK WHICH APPLIES:

ASSOCIATE DEGREE NURSING _____ 1st YEAR _____ (OR) 2nd YEAR _____

PRACTICAL NURSING _____

NUMBER OF CREDIT HOURS COMPLETED IN THE NURSING PROGRAM? _____

EXPECTED DATE OF GRADUATION: _____

Applicants must submit a 250-300 word essay entitled “My Goals after I Complete My Nursing Education” and attach one personal reference.

I CERTIFY THAT THE ABOVE INFORMATION IS A TRUE AND ACCURATE STATEMENT OF MY FINANCIAL STATUS. I GRANT PERMISSION TO THE DESIGNATED SCHOLARSHIP COMMITTEE AND/OR DONOR TO REVIEW ANY AND ALL STUDENT FILES AND ACADEMIC TRANSCRIPTS NECESSARY TO AWARDING AND RETAINING SCHOLARSHIPS.

Please sign and initial that you have read and understand the requirements:

_____ I understand that my name and award information will be released to the donor.

Signature

Date

**Bring completed application to the financial aid office at the New Bern or Havelock, or
Cherry Point offices. Attention: Carolyn Ward, Financial Aid Advisor II
INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.**

DEADLINE: DECEMBER 31, 2017

CRAVEN COMMUNITY COLLEGE IS AN EQUAL EMPLOYMENT OPPORTUNITY/
AFFIRMATIVE ACTION INSTITUTION

Office Use

GPA _____

Credit Hours _____

ADN 1st Year _____ 2nd Year _____ PN _____

Date Received ____/____/____

Initials: _____