



HEALTH PROFESSIONS
EDUCATION FOUNDATION

Giving Golden Opportunities

Bachelor Science of Nursing Scholarship Application



Spring Postmark Deadlines: March 24, 2009
Fall Postmark Deadlines: September 11, 2009

*Giving Golden
Opportunities by:*

*Increasing the supply of
registered nurses practicing
in medically underserved areas*

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

*Helping students pursue a
career in the health professions*

*Awarding nurses who
are dedicated to practicing in underserved
communities*

Application Instructions



If you want receipt confirmation of your application packet, please submit one self-addressed stamped envelope with your application.

You must be a California resident and a citizen or permanent resident of the U.S. to apply.

The purpose of the Bachelor of Science Nursing Scholarship Programs is to increase the number of registered nurses (RN) practicing in medically underserved areas of California.

Applications for the Bachelor of Science Nursing School Program are accepted biannually. Monies awarded under these programs are intended to pay tuition, required fees, books, supplies, and educational equipment costs related to the applicants registered nurse or pre-nursing education. All awards are subject to the availability of funding.

Awardee will be required to practice as a RN in a MUA for a minimum of two(2) years by providing direct patient care on a full-time basis (40 hours per week)

The Foundation outlines the provisions which must be met to fulfill the obligations under this program. Failure to comply with the terms of the contract may result in the awardee's repayment of the funds awarded plus interest.

EXISTING SERVICE OBLIGATIONS

Applicants who owe a service obligation to practice direct patient care to another entity entered into before filing an application with the Foundation are ineligible to receive a scholarship. Previous obligations must be completed before applying. Awardees who breach their contract with the OSHPD will not be allowed to reapply for additional awards.

SELECTION CRITERIA

Selection for the Bachelor of Science Nursing Scholarship and Loan Repayment Programs is based solely on information contained in the application and supporting documentation. The application must be complete, signed and dated to be considered eligible. Selection for awards is based on the following criteria:

Work Experience - nursing and non-nursing work experience in a medically underserved area (MUA).

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 completing education 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.

Community Background - family structure, soci-economic background and community where applicant grew up; for example, rural, inner city/urban, suburban, or MUA.

Fluency - fluency in a language other than English must be verified on

the Employment or Certification of Enrollment Form.

Academic Performance - prior and current academic performance; potential for future academic success.

Priority will be given to: applicants whose community background and commitment indicates the likelihood of long-term employment in a MUA even after the service obligation has ended.

Awards are made on a competitive basis. Each part of the application must be completed. All supporting documentation must be submitted by the appropriate deadline. Only complete applications will be evaluated. The Foundation will not notify individuals if their application is incomplete.

SCHOLARSHIP ELIGIBILITY

Students may receive up to **\$13,000** for the **Bachelor of Science Nursing Scholarship**. Scholarships are funded for one (1) academic year, generally two (2) semesters or three (3) quarters. Your graduation date may impact the amount of funding you are eligible to receive.

Scholarships are available to students who are enrolled or accepted in a Bachelor of Science nursing program. Awardees must sign a contract with the Office of Statewide Health Planning and Development (OSHPD)/Health Professions Education Foundation and agree to the following terms:

Complete a two (2) year service obligation to practice in a MUA of California as a RN providing full-time (40 hours per week or its equivalent) direct patient care

Be a full-time or part-time student (no less than six (6) units) in a California accredited school.

Maintain a minimum cumulative GPA of 2.0 each year scholarship funds are sought.

SUBMIT THE FOLLOWING

1. Completed Application

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

2. Official Transcript(s) Related To Your Nursing Education

If you are a student in your first year of the nursing program and your transcripts do not reflect your nursing education, submit your most current transcript.

The transcript(s) must be marked official by the school and delivered to the Foundation in a sealed envelope. The Foundation will not accept unofficial transcripts, copies or print outs of transcripts, or transcripts in an open/unsealed envelope.

3. Personal Statement (Part E of the Application)

Your statement must be typed and no more than two (2) pages. Statement must provide a comprehensive response to each question. Restate and

Application Instructions (cont.)



number each question along with your answer. 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. 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.

To receive maximum credit for community service, a letter from the agency where service was provided must be submitted.

5. Graduation Date Verification Form

This form must be signed by the nursing program director or a faculty member authorized to sign on the director's behalf. The Graduation Date Verification Form is enclosed as part of the scholarship application. Applicants can also download this form from the Foundation's Website at www.healthprofessions.ca.gov.

6. Linguistic Competency

Fluency in a language must be verified on the Employment or Graduation form from employer or school faculty.
Student Aid Report (SAR)

7. Students must submit the final 2009-2010 SAR. The SAR must indicate the student's expected family contribution (EFC). The FAFSA is available from all college financial aid offices and is also available on the Internet at www.ed.gov/offices/OPE/express.html. **DO NOT SUBMIT FAFSA.**

OR

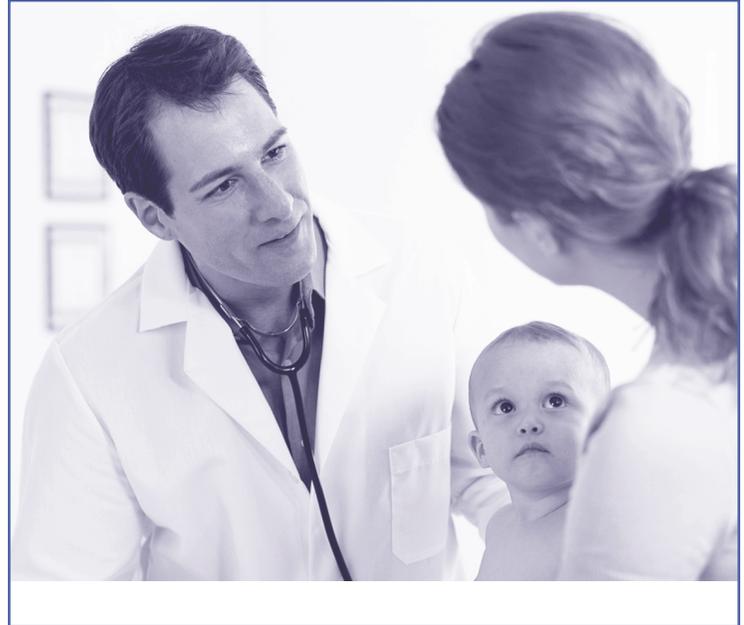
Signed 2008 Federal Tax Return and all W-2s - Applicants who do not apply for financial aid must submit a complete copy of their 2008 Federal Tax Return and all W-2s. **DO NOT SEND YOUR STATE TAX RETURN.**

Application Submission

Applications must be postmarked by the deadline. In order to be eligible, each part of the application must be completed. All supporting documentation must be submitted by the appropriate deadline. The Foundation will not notify applicants if their application is received incomplete. Applicants are urged to contact the Foundation at (800) 773-1669 prior to the final filing date to verify if their application was received complete. Do not bind or submit applications in a loose-leaf binder.

NOTIFICATION OF AWARDS

The Foundation will notify applicants of their application results within 120 days of the postmark deadline.



For additional information on how to complete this application, please visit the Foundation's website to access Frequently Asked Questions, a technical assistance call and a powerpoint presentation.

SPRING POSTMARK DEADLINE: MARCH 24, 2009

FALL POSTMARK DEADLINE: SEPTEMBER 11, 2009

Submit applications to:

**Health Professions Education Foundation
Bachelor of Science Scholarship Programs
400 R Street, Suite 460
Sacramento, CA 95811
(800) 773-1669 or (916) 326-3640**

Application

Please refer to the application instructions when completing the application. Complete all pages of the application form, and make sure all supporting documents are submitted with your application. All documents must be postmarked by the application deadline. Late or incomplete application packets will not be evaluated.

Please enter the award amount you are requesting (up to \$13,000): _____

PART A - PERSONAL INFORMATION

Applicants may apply for only one award using this application (Please type or print your answers legibly in the space provided).

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	Last Name:	First Name:	Middle Initial:
CA Drivers License Number:		*Social Security Number:	
Mailing Address:			
City:		State:	Zip Code:
County:			
Permanent Address (if different than above):			
City:		State:	Zip: Code
County:			
Home Phone: ()		Date of Birth:	
Cell Phone: ()		E-mail Address:	
Work Phone: ()		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status (Optional): <input type="checkbox"/> Unmarried <input type="checkbox"/> Married
Are you a citizen or permanent resident of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a California resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of dependents other than self and spouse (as declared on tax returns or student aid report):			
Which best describes your ethnic background:			
<input type="checkbox"/> African American	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Native American	
<input type="checkbox"/> Asian American	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Pacific Islander	
<input type="checkbox"/> Other (Please specify) _____			

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 Register Nurse 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 Program 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.

FOR OFFICIAL USE ONLY

Recd:	Compl / Inc:	Omitted: App Pgs	GDV	EVF	SAR	TAX	LoR	Other
Input By:	MUA: Yes / No	CT#:						
Reviewed By:	Comments:							

Applicant's Name: _____



PART B – WORK EXPERIENCE

1. Are you currently employed as a registered nurse? Yes No

If yes, provide license # _____

Expiration Date: ____/____/____

PART C – COMMUNITY BACKGROUND

1. Have you lived in an economically disadvantaged background (income below the federal poverty level, low income, subsidized income, qualified for public programs, lived in rural, inner city or medical underserved area) for at least two years?

Yes No

If you selected yes; please describe in your personal statement under question #5.

If yes, please check the appropriate range of years.

2-5 years 6-10 years 11 or more years

PART D – LINGUISTIC COMPETENCY

1. List any languages in which you are fluent. This must also be verified by the applicant's employer on the Employment Verification or Certification of Enrollment Form.

1st language: _____

2nd language: _____

3rd language: _____

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 a comprehensive response to each question.

1. What kind of work would you like to do immediately after graduation?
2. What kind of work do you think you'll be doing in five (5) years?
3. What are your professional goals for the next five (5) to ten (10) years as they relate to your nursing profession?
4. Describe any community service, volunteer activities, or club memberships within the past five (5) years (**Please attach any letters of recommendation you may have. Do not include experience for which you received academic credit.**)
5. Briefly describe your family background including: your parent's 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 and any other factors that help describe your family's socio-economic situation.
6. Describe how your background is relevant to your interest in pursuing a nursing career. Do you see your background as an advantage, disadvantage, or both?
7. Describe your experience in cross-cultural situations which may include employment, school, travel abroad, and family settings.



Applicant's Name: _____

PART F – QUESTIONNAIRE

Do you currently owe a service obligation to another entity?
 Yes No

“Service Obligation” means 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.

Are you a previous awardee of the Foundation? Yes No
If yes, please enter the contract # _____

Are you currently Military Veterans? Yes No

Are you the first in your family to attend college? (optional)
 Yes No

Where did you hear about the BSN Scholarship and BSN Loan Repayment Program? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Work (employer or co-worker) | <input type="checkbox"/> Friend/Acquaintance |
| <input type="checkbox"/> TV | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Other Website | <input type="checkbox"/> Foundation Website |
| <input type="checkbox"/> Newspaper or Publication (please specify) _____ | <input type="checkbox"/> Advertisement |
| <input type="checkbox"/> Organization or Affiliation (please specify) _____ | |
| <input type="checkbox"/> Other Source (please specify) _____ | |

Where did you receive the BSN Scholarship Program application? (Check only one)

- | | |
|---|--|
| <input type="checkbox"/> Program Director/Instructor | <input type="checkbox"/> Foundation office |
| <input type="checkbox"/> Foundation Web site | <input type="checkbox"/> Other Web site |
| <input type="checkbox"/> Work (employer/co-worker) | <input type="checkbox"/> Friend/Acquaintance |
| <input type="checkbox"/> Other (please specify) _____ | |



PART G – 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 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: _____ Middle Initial: _____

Applicant's Signature: _____

Date: _____

SCHOLARSHIP CHECKLIST

- 1. Completed Application (signed)
- 2. Official Transcript(s) related to your nursing education
- 3. Personal Statement
- 4. Two (2) Professional Letters of Recommendation (dated within 6 months)
- 5. Graduation Date Verification Form
- 6. Signed 2009/2010 Student Aid Report or 2008 Federal Tax Return and all W-2s
- 7. Copy of cost of attendance/tuition for BSN program.

Work History

➤ Please list all work experience you have had. **List most recent employer first** (maximum of 4 employers).

Employer's Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
County: _____
Supervisor's Name: _____
Telephone Number: _____
Your Position/Title: _____ Monthly Salary: _____

Full-time OR Part-time

Employment Start Date: ____/____/____
Employment End Date: ____/____/____
Average hours worked (please choose only one):
_____/day ____/week ____/month

Brief Description of your job duties: _____

Employer's Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
County: _____
Supervisor's Name: _____
Telephone Number: _____
Your Position/Title: _____ Monthly Salary: _____

Full-time OR Part-time

Employment Start Date: ____/____/____
Employment End Date: ____/____/____
Average hours worked (please choose only one):
_____/day ____/week ____/month

Brief Description of your job duties: _____

Employer's Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
County: _____
Supervisor's Name: _____
Telephone Number: _____
Your Position/Title: _____ Monthly Salary: _____

Full-time OR Part-time

Employment Start Date: ____/____/____
Employment End Date: ____/____/____
Average hours worked (please choose only one):
_____/day ____/week ____/month

Brief Description of your job duties: _____

Employer's Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
County: _____
Supervisor's Name: _____
Telephone Number: _____
Your Position/Title: _____ Monthly Salary: _____

Full-time OR Part-time

Employment Start Date: ____/____/____
Employment End Date: ____/____/____
Average hours worked (please choose only one):
_____/day ____/week ____/month

Brief Description of your job duties: _____

Graduation Date Verification Form

(For Scholarship Applicants Only)



ATTENTION! The completed form must bear an original ink signature. Photocopies and faxed copies of the completed form are not acceptable.

FORM 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)

Student's Last Name: _____ First Name: _____ Middle Initial: _____

School Name: _____

Program Enrolled: _____

School Mailing Address: _____

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

Year Entered (Month / Year): _____ Expected Graduation Date (Month / Year): _____

Enrollment Status: F/T or P/T # of units currently enrolled: _____

Current GPA: _____ or # of units equivalent if on a modular system: _____

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

Please attach a copy of any record showing the tuition costs for the BSN program the student is enrolled or accepted in.

Through our selection process, I have determined that the applicant can speak the following language(s):

1st language: _____

2nd language: _____

3rd language: _____

Name: (Please Print) _____

Signature: _____

Title: _____

Phone Number: _____

Fax Number: _____

Email: _____

Date: _____





HEALTH PROFESSIONS EDUCATION FOUNDATION

Giving Golden Opportunities

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