Nursing Education Scholarship **Date:**

Bridgeport Hospital School of Nursing Alumni Association I, Inc.

(All areas must be completed in its entirety and submitted for consideration of a scholarship)

Last Name **First Name** **Middle Initial** **Maiden Name**

Address: **Number & Street** **City** **State** **Zip Code**

Telephone- Home: __ **Cell: __**

Email: _ **Date of Birth: __**

BHSN Class of:_ Degree being sought: _ **BHSN Alumni 1 member:__Yes No**

Are you currently Employed: _Yes _No Name of Employer:___

Tuition Reimbursement from your Employer:__Yes __No Amount received for semester:__

List other grants or scholarships received for this semester:__

Total amount paid out of pocket for above course(s) after tuition reimbursement:___

Name & Address of College/University:____

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Name of Course(s)	No. of Credits	Cost per Credit

Name of Textbook or other expenses	Cost

Write a short paragraph including and complete the checklist below:

- **Your Nursing Career Goals**
- **Why do you feel that you should be granted this scholarship**
- **Indicate financial need**

BHSN AAI CONTINUING SCHOLARSHIP APPLICATION CHECK LIST

Date of Course/es	College Attending	Proof of Course Registration and Eligible courses/ credits	Cost per Course/ Credit	Employer tuition reimbursement	Other scholarship or grants received	Amount paid out of pocket for course /courses	Proof of Course Payment	Proof of Textbook payment	Sealed or Electronic Official Transcript	Application complete, Yes/No/ pending

Signature_____ Date_____

Submit Application to: Caren Silhavey, 25 Morning Glory Terr., Stratford, Ct 06614 or email to: Silhavey@att.net