NURSING SCHOLARSHIP APPLICATION
2026-2027 ACADEMIC YEAR

P.O. Box 2401 | Bakersfield, CA 93303
(661) 541-0190
WEBSITE: supportbakersfield.org
EMAIL: contactbmhf@commonspirit.org

To be considered for an academic nursing scholarship from the BMH Foundation, please confirm that you meet the following requirements:

Are you enrolled in a nursing education program? YES ☐ NO ☐

(If you checked NO, do NOT proceed with this application. You must be currently enrolled to qualify.)

If you checked YES, please answer the following:

Current School Attending? ____________________________________ Current GPA: _________

Current Year (e.g. first-year, second-year, first-year advanced degree etc.)? ______________________

Anticipated graduation date? _______________

Are you employed by Bakersfield Memorial Hospital? YES ☐ NO ☐

A complete application includes the following:

1. **New RN Students: Two** completed recommendation forms (attached). One must be from a nursing school prerequisite professor; the second may be from a professor or a medical field employer.
2. **Returning RN Students: Three** completed recommendation forms (attached). Requirements include one from a nursing school prerequisite professor, one from a professor or medical field employer, and one from a clinical supervisor.
3. **Transcripts:** Official transcripts providing proof of met course requirements. *Official transcripts are required, please email to: www.contactbmhf@commonspirit.org.*
4. **Enrollment Status: Proof of current** enrollment in a nursing program **with at least one year of coursework remaining and in good standing.**
5. **Residency:** Applicants must reside in or attend school in Kern County, California.
6. **DEADLINE: Please ensure all documentation is received by Friday, May 15, 2026 at 3pm to be considered.**
7. **INTERVIEW**: All qualified applicants will be asked for an in-person interview.

PERSONAL INFORMATION

First Name	**Middle Initial**	**Last Name**
Current Address	**City**	**State/Zip Code**
Mailing Address (if different from above)	**City**	**State/Zip Code**
Mobile Phone (Please provide for interview scheduling)		**Home, Work or Message Phone**

Email Address (Please provide for interview scheduling): ______________________________

EMPLOYMENT INFORMATION

Are you currently employed? ________Yes _______No If yes, ______Full-time ______Part-time

Current employer (name/address)	Supervisor's name/phone number	From	To

Previous employer (name/address)	Supervisor's name/phone number	From	To

Medical experience (either as a volunteer or paid employee)

Department currently working	Supervisor's name/extension	From	To
Department previously worked	**Supervisor's name/extension**	**From**	**To**
Department previously worked	**Supervisor's name/extension**	**From**	**To**

ACADEMIC INFORMATION

Please provide the following information regarding your current academic status and goals:

College/University Now Attending	From	To	GPA
College/University Attended	**From**	**To**	**GPA**
College/University Attended	**From**	**To**	**GPA**
High School Attended	**From**	**To**	**GPA**

Degree held *(if applicable):* ____

Degree sought: ____

Ultimate goal/final degree hoping to attain: ____

Number of classes currently being taken: ____

ACTIVITIES, SPECIAL RECOGNITION, COMMUNITY INVOLVEMENT

Use additional page if necessary.

High School: Activities, clubs, etc.	Special recognition, awards

College/University: Activities, clubs, etc.	Special recognition, awards

Community Involvement: Activities, clubs, etc.	Special recognition, awards

Employment: Recognition	Special recognition, awards

ACADEMIC SCHOLARSHIPS, GRANTS & REIMBURSEMENTS

Academic Scholarships & Grants Awarded: (Use an additional page if necessary.)

1. Source: ______________________________

   Amount $______________________________

   Date Applied: ______________ Date Awarded: ______________

2. Source: ______________________________

   Amount $______________________________

   Date Applied: ______________ Date Awarded: ______________

3. Source: ______________________________

   Amount $______________________________

   Date Applied: ______________ Date Awarded: ______________

4. Source: ______________________________

   Amount $______________________________

   Date Applied: ______________ Date Awarded: ______________

HAVE YOU APPLIED AND/OR RECEIVED COMPENSATION FROM THE BAKERSFIELD MEMORIAL HOSPITAL TUITION REIMBURSEMENT PROGRAM? IF YES, PLEASE PROVIDE THE DATE YOU APPLIED AND LIST THE AMOUNT RECEIVED.

DATE: ______________ **AMOUNT RECEIVED: $**______________

AUTOBIOGRAPHICAL ESSAY

Please attach a separate page, with a minimum of one typewritten document to this application, describing your educational and career goals, your community and school involvement and any special or unique circumstances you would like to share with the scholarship committee. You may also use this opportunity to explain or elaborate on your qualifications for this scholarship.

____

Please sign and date this application below.

____

Signature of Applicant

Date of Application: ______________________________

Bakersfield Memorial Hospital Foundation

Nursing Scholarship Recommendation Form

Recommendation Form: The recommendation form is to be completed by a nursing professor, an employer in the medical field, or a clinical supervisor. Students should refer to the eligibility requirements to determine the appropriate individual to complete this document.

Person completing this form should mail to: Bakersfield Memorial Hospital Foundation, PO Box 2401, Bakersfield, CA 93303, or give it to the student to return with application.

Applicant's Name:

____

Name of Nursing School:

____

1. Does this student exhibit a sound nursing knowledge base? ____________ **Yes** __________ **No**

Comments:

____

____

____

2. Does this student exhibit responsibility and integrity? ___________ **Yes** ___________ **No**

Comments:

____

____

____

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

____

____

____

(Please use an additional page if more space is necessary.)

____

Name of person completing form ____

Title: ______________________________ Signature:__________________________ Date:___________

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Applicant's Name:

____

Name of Nursing School:

____

1. Does this student exhibit a sound nursing knowledge base? ____________ **Yes** __________ **No**

Comments:

____

____

____

2. Does this student exhibit responsibility and integrity? ___________ **Yes** ___________ **No**

Comments:

____

____

____

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

____

____

____

(Please use an additional page if more space is necessary.)

____

Name of person completing form ____

Title: ______________________________ Signature:__________________________ Date:___________

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Applicant's Name:

Name of Nursing School:

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1. Does this student exhibit a sound nursing knowledge base? ____________ **Yes** __________ **No**

Comments:

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2. Does this student exhibit responsibility and integrity? ___________ **Yes** ___________ **No**

Comments:

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

(Please use an additional page if more space is necessary.)

Name of person completing form ____

Title: _______________________________ Signature:___________________________ Date:___________