Bakersfield Memorial Hospital Foundation

K & S Small
NURSING SCHOLARSHIP APPLICATION

Mailing Address:
P.O. Box 2401 | Bakersfield, CA 93303

Phone (661) 541-0190
Fax (661) 395-0328

The following requirement must be met before your application will be considered for an academic scholarship from the BMH Foundation:

Are you currently 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:

What school do you currently attend? _____ Current GPA: _____

What year nursing student are you (e.g. first-year, second-year, third-year, fourth-year)? _____

What is your anticipated graduation date? _____

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

A complete application includes the following:

1. **New RN students** must have **two** recommendation forms completed; one must be from a professor who taught a nursing school prerequisite; the second may be from a professor or an employer if the employment is in the medical field. Forms are attached.
2. **Returning students in the RN program who have completed at least one clinical rotation** must have **three** recommendation forms completed; one must be from a professor who taught a nursing school prerequisite; the second may be from a professor or an employer if the employment is in the medical field; the third must be from a clinical supervisor. Forms are attached.
3. Applicant must provide proof of having met course requirements. ***OFFICIAL transcripts may be mailed via USPS to the foundation mailing address OR official electronic transcripts may be emailed to: lana.pollema@dignityhealth.org.***
4. Applicant **must be currently enrolled in a nursing program** with at least **one year of course work remaining** and considered to be a **student in good standing**.
5. Applicant must reside in or be attending school in Kern County, California.
6. **Completed applications and all required documentation must be received by May 19, 2023 at 5:00pm in the BMH Foundation office to be considered**.
7. **DO NOT send documents by registered, certified, Priority or Express mail.**

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 | **Home, Work or Message Phone**

Email Address

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

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 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 BMH tuition reimbursement program?
If yes, please provide the date you applied, amount received, etc.

STUDENT FINANCIAL INFORMATION

1. If you are going to be claimed as an exemption or dependent on your parent's tax return, then please complete Section A.

2. If you are not an exemption, and are married or filing your own return, please complete Section B.

SECTION A: (Dependent Student) Parents' Marital Status: _____Family Size:_____	
Applicant's 2022 Adjusted Gross Income or Earned	$ _____
Income Parent's 2022 Adjusted Gross Income or Earned	$ _____
Non-Taxable Income: (Social Security, AFDC, Student Loans, etc.)	$ _____
TOTAL FAMILY INCOME	$ _____

SECTION B: (Independent Student) Current Marital Status: _____Family Size:_____	
Applicant's 2022 Adjusted Gross Income or Earned	$ _____
Income Spouse's 2022 Adjusted Gross Income or Earned	$ _____
Non-Taxable Income: (Social Security, AFDC, Student Loans, etc.)	$ _____
TOTAL FAMILY INCOME	$ _____

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

To be completed by a nursing professor, employer if the employment is in the medical field, and a clinical supervisor (student should refer to eligibility requirements to determine who should complete this form).

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

Applicant's name_____

School of Nursing_____

1. Does this student exhibit a sound nursing knowledge base? ____ Yes ____ No

Comments_____

_____

_____

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

Comments_____

_____

_____

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

_____

_____

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

Name of person completing form _____

Title:_____ Signature:_____Date:_____

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Comments_____

_____

_____

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

Comments_____

_____

_____

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

_____

_____

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

Name of person completing form _____

Title:_____ Signature:_____Date:_____

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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_____

_____

_____

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

_____

_____

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

Name of person completing form _____

Title:_____ Signature:_____Date:_____