

**Ralph Smith, Jr. / Helen & Leslie Riechel / Small  
NURSING SCHOLARSHIP APPLICATION**

P.O. Box 2401 | Bakersfield, CA 93303  
(661) 327-4647, ext. 10190  
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, first-year advanced degree etc.)? \_\_\_\_\_

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 are required. Internet screen prints of class registration and/or transcripts will not be considered.**
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 April 30, 2020 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

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

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

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Medical experience (either as a volunteer or paid employee)

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Department currently working Supervisor's name/extension From To

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Department previously worked Supervisor's name/extension From To

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Department previously worked Supervisor's name/extension From To

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**ACADEMIC INFORMATION**

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College/University Now Attending From To GPA

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College/University Attended From To GPA

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College/University Attended From To GPA

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High School Attended From To GPA

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Degree held (if applicable): \_\_\_\_\_

Degree sought: \_\_\_\_\_

Ultimate goal/final degree hoping to attain: \_\_\_\_\_

Number of classes currently being taken: \_\_\_\_\_

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**ACTIVITIES, SPECIAL RECOGNITION, COMMUNITY INVOLVEMENT**

(Use additional page if necessary)

<b>High School: Activities, clubs, etc.</b>	<b>Special recognition, awards</b>

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

<b>Community Involvement: Activities, clubs, etc.</b>	<b>Special recognition, awards</b>

<b>Employment: Recognition</b>	<b>Special recognition, awards</b>

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**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.*

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**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 2019 Adjusted Gross Income or Earned Income	\$ _____
Parent's 2019 Adjusted Gross Income or Earned Income	\$ _____
Non-Taxable Income: (Social Security, AFDC, Student Loans, etc.)	\$ _____
<b>TOTAL FAMILY INCOME</b>	<b>\$ _____</b>

**SECTION B: (Independent Student)**

Current Marital Status: \_\_\_\_\_ Family Size: \_\_\_\_\_

Applicant's 2019 Adjusted Gross Income or Earned Income	\$ _____
Spouse's 2019 Adjusted Gross Income or Earned Income	\$ _____
Non-Taxable Income: (Social Security, AFDC, Student Loans, etc.)	\$ _____
<b>TOTAL FAMILY INCOME</b>	<b>\$ _____</b>

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## **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.***

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**Please sign and date this application below.**

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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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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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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 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_