

# SAIDIE ORR DUNBAR NURSING SCHOLARSHIP APPLICATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Present Program of Study

Institution: \_\_\_\_\_

Major Area of Study: \_\_\_\_\_

Clinical Area (specialization): \_\_\_\_\_

Date Program Was Started: \_\_\_\_\_

Date Program Will Be Completed: \_\_\_\_\_

## Required Information For Application

APPLICANT MUST HAVE BEEN ACCEPTED INTO A NURSING PROGRAM AND HAVE AN AVERAGE GPA OF 3.00.

A. NOTE: This application will not be considered if any of the following items are missing.

1. CURRENT CURRICULUM VITAE (Resume)
2. TRANSCRIPTS OF UNDERGRADUATE WORK COMPLETED
3. FINANCIAL STATEMENT: Include with detail the following:

A. INCOME: Please list all incomes available to you during your course of study.

- ◆ Earned income from employment per calendar year \$ \_\_\_\_\_
- ◆ Interest income per calendar year \$ \_\_\_\_\_
- ◆ Income from spouse, family or significant other per calendar year \$ \_\_\_\_\_
- ◆ Grant, loan and/or scholarship income per calendar year \$ \_\_\_\_\_

Please list below all individual sources of income:

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

TOTAL INCOME \$ \_\_\_\_\_

B. NUMBER OF DEPENDENTS: \_\_\_\_\_

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C: EXPENSES: Please list all expenses on a monthly basis	Monthly Payment.
◆ Rent or House Payment	\$ _____
◆ Total Credit Card and/or Installment Payments Name of Account	
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
◆ Other Living Expenses (meals, transportation, utilities)	\$ _____
◆ Tuition (per month on the average) .	\$ _____
◆ Books (per month on the average)	\$ _____
◆ Office Supplies & Photocopying (educational requirements)	\$ _____
<b>TOTAL MONTHLY EXPENSES:</b>	<b>\$ _____</b>

D. BRIEFLY DESCRIBE NEED FOR SCHOLARSHIP:

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## 4. REFERENCES

**Three** written letters of reference - One from a faculty member, principle or dean and **Two** from employers or teachers. List names, addresses and phone numbers for the attached references.

A. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

B. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

C. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## 5. GOALS

A. **PROFESSIONAL OBJECTIVES:** Please be specific about short term and long term career goals after you graduate. Do you have a particular type of position in mind? If so, please describe. Where do you hope to practice? Explain how the academic preparations you are pursuing will prepare you to meet these stated goals.

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B. Please explain how you feel the accomplishment of your career goals will influence the future of health care in the State of Oregon.

### 6. ACADEMIC PLAN

A. Total number of credits in program and estimated length of time required with present financing. Indicate research requirement, if appropriate.

B. Please describe the changes in the time frame above if scholarship fund is available.

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## 7. BELIEFS AND VALUES ABOUT NURSING AND HEALTH

Mail Applications To:

Saidie Orr Dunbar Nursing Education Fund  
c/o American Lung Association of Oregon  
7420 SW Bridgeport Road, Suite 200  
Tigard, OR 97224-7790

**FAXED APPLICATIONS WILL NOT BE EXCEPTED**

**INCLUDE IN YOUR PACKET ALL REQUIRED REFERENCES,  
TRANSCRIPTS AND PAPERS.**

If you have questions call:

American Lung Association of Oregon  
503-924-4094 (Portland) or 1-800-545-5864 (within Oregon)  
Beth Frerichs

All grants are awarded based upon available funds.

