Trinity College of Nursing and Health Sciences

Scholarship Application

Please complete each item below:

Name: _____ Phone: _____/_____-_____
(Last Name, First Name, Middle Initial)

Current Address: _____, _____, ____. _____
(Street Address) (City) (State) (Zip Code)

Permanent (Former) Hometown _____ Hometown Newspaper_____
(City, State)

E-mail Address _____

I have registered (plan to register) for _____* credit hours.

Current GPA: _____*

*Important information, *do not omit.*

I am a student in:

	Year (1-4)	Semester (1-2)
__ Nursing-ASN	_____	_____
__ Nursing-(circle one) BSN-A, BSN-B, BSN-C	_____	_____
__ Radiography	_____	_____
__ Respiratory Care	_____	_____

Please list other financial or gift assistance you are currently receiving:

_____

_____

ALUMNI SCHOLARSHIP (only complete if you are an alumnus requesting funds for continuing or higher education)

I am a dues-paying member of Trinity College Alumni Association. ___yes ___no

Program of Study _____ Year of Graduation: _____

Current College Attending_____ Hours Completed: _____

Other Post Secondary Education: _____ Degrees Attained: _____

(The following information is optional and will not affect your scholarship eligibility.)

Are you employed by Trinity Regional Health System? ___yes ___no

If yes, campus_____department_____position_____

Are you currently receiving scholarship assistance from other sources? ___yes ___no

If yes, from where / whom (community, state or national organization)? _____

All Applicants: PLEASE ATTACH TO THE APPLICATION FORM a brief statement of your educational and professional goals and personal/financial need for scholarship assistance in support of your application.

Submit completed application form and above requirements

To: Trinity College
2122 25th Ave.
Rock Island IL 61201

If you have any questions, please call the Student Services Office at:
(309) 779-7700

I confirm that the information on this application is accurate and do hereby agree to notify Trinity College of Nursing and Health Sciences Schools of any change. I also authorize Trinity College of Nursing and Health Sciences Schools to release academic and financial aid information to the Trinity College Scholarship Committee.

Applicant's Signature_____

Date _____

FOR OFFICE USE ONLY

Date Received _____

Narrative Yes___ No___

Scholarship Awarded Yes___ No___

Scholarship _____

Amount_____

Account Number _____

Student ID Number #_____