TRI-CITY HOSPITAL AUXILIARY

APPLICATION FOR NURSING SCHOLARSHIP 2024-2025

4002 Vista Way, Oceanside, CA 92056 www.tricityhospitalauxiliary.org Tel: 760-940-3125

Student Name: _____ _____
Last First

Address: _____
Street

_____ _____ _____
City State Zip

Phone Number: (_____) _____ Email: _____

Student ID # _____ Cumulative Grade Point Average _____ Nursing Course GPA _____

Nursing School currently attending: _____

Nursing Program in which you are enrolled (LVN, RN, BSN): _____

When did you begin this program? _____

Year/semester of Nursing School in which you are currently enrolled? _____
(Ex: 1st year, 2nd semester)

When do you expect to graduate? _____
`
(Ex: Spring 2025)

Are you currently receiving a Pell Grant ____ CCPG (formerly BOGW) ____ Scholarship ____ Student Loan _____?

Please confirm the due date with your college scholarship coordinator. The colleges will deliver all applications to the Tri-City Hospital Auxiliary Office no later than Noon on TUESDAY FEBRUARY 13, 2024. Applications arriving after that date will not be considered.

AUTHORIZATIONS

I hereby authorize the release of this information to the Tri-City Hospital Auxiliary, donors, and the college or university I am currently attending. If awarded a scholarship, you have my permission to release this information to the media and donors.

Signature: _____ Date: _____

I authorize the college or university I am attending to release my financial aid information to Tri-City Hospital Auxiliary.

Signature: _____ Date: _____

I authorize Tri-City Hospital Auxiliary Scholarship Committee to receive a statement that I am still enrolled in the Nursing program at my college or university.

Signature: _____ Date: _____

I affirm that the information contained herein is true and accurate to the best of my knowledge and belief.

Signature: _____ Date: _____