

Nursing Education Scholarship Date: _____
Bridgeport Hospital School of Nursing Alumnae Association 1, Inc.
(All areas must be completed in its entirety and submitted for consideration of a scholarship)

Last Name **First Name** **Middle Initial** **Maiden Name**

Address: **Number & Street** **City** **State** **Zip Code**

Telephone- Home: ___ **Cell:** ___

Email: ___ **Date of Birth:** ___

BHSN Class of:___ **Degree being sought:** _ **BHSN Alumnae 1 member:** ___Yes ___ No

Are you currently Employed: _Yes _No **Name of Employer:**___

Tuition Reimbursement from your Employer: ___Yes ___No **Amount received for semester:** ___

List other grants or scholarships received for this semester: ___

Total amount paid out of pocket for above course(s) after tuition reimbursement: ___

Name & Address of College/University: _

Name of Course(s)	No. of Credits	Cost per Credit

Name of Textbook or other expenses	Cost

Write a short paragraph including and complete the checklist below:

- **Your Nursing Career Goals**
- **Why do you feel that you should be granted this scholarship**
- **Indicate financial need**

BHSN AAI CONTINUING SCHOLARSHIP APPLICATION CHECK LIST

Date of Course/es	College Attending	Proof of Course Registration and Eligible courses/credits	Cost per Course/Credit	Employer tuition reimbursement	Other scholarship or grants received	Amount paid out of pocket for course /courses	Proof of Course Payment	Proof of Textbook payment	Sealed or Electronic Official Transcript	Application complete, Yes/No/pending

Signature _____ **Date** _____

Submit Application to: Caren Silhavey, 25 Morning Glory Terr., Stratford, Ct 06614 **or email to:** Silhavey@att.net