POCONO HEALTH FOUNDATION

Jennie Cramer, Robert A. Gordon, R. Dale Hughes

NURSING SCHOLARSHIP PROGRAM

Application

Name: ____

Address: ____

City/State/Zip Code: ______________________________________

Phone: (____)____________________ Email address: ______________________

School Name: ____

Address: ____

City/State/Zip Code: ______________________________________

School Phone: (_____)________________ Email: ________________________

Name of Nursing Program/School: ______________________________

Degree to be awarded upon completion: __________________________

Anticipated program completion date: ____________________

*Current Academic Standing:

Class Ranking ____________________ and/or GPA ______________________

Current Employment Status:

Title: ____

_____**Full time** _____**Part time**

Employer:____

Prior Employment/Experience in Healthcare *(please list)*:

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Special Clinical Interest(s):

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Awards/Recognitions *(list year and organization)*:

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Community Service:

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**Please attach a copy of school records validating the information supplied on the application. (RNs or LPNs pursuing another level of education may provide RN/LPN class rankings.).*
**Please enclose two letters of recommendation.*
**Applications must be received by March 31st of the current year.*
**Send or fax completed application and supporting materials to:*

Pocono Health Foundation
206 East Brown Street
East Stroudsburg, Pa 18301
(570) 476-3530 *phone*
(570) 476-3469 *fax*