

HISNA Leadership

Scholarship Application

Please submit completed application by **January 29, 2016 11:59 PM**

Scholarship recipients will be notified in **May 2016**

Eligibility Criteria

* Be currently enrolled in a Nursing Programthat is a member of HISNA.
* Must bean NSNA Member for at least 2 full semesters ( i.e. 1 full year)
* Must bea HISNA Member in good standing (no lapse of more than 30 days in membership for NSNA)
* Demonstrate leadership skills by organizing at least 1 event at the State Level and/or organizing and/or participating at least 1 event at the School Level
* Demonstrate community service
* Demonstrate academic nursing excellence with a Nursing GPA at least 2.5 / 4.0

Required Documentation

* Proof of NSNA Membership Card
* Most recent copy of an Official Transcript
* One (1) letter of recommendation from a peer stating why this applicant is considered a leader.

Scholarship Information

The Hawai’i Student Nurses’ Association (HISNA) will be awarding 1 deserving nursing student, who best exemplifies leadership. The HISNA Leadership Scholarship is a $250 award donated by Dr. Edna Magpantay-Monroe, faculty consultant/adviser to help with educational expenses.

Applicant Information

**Name:**  **Date of Application:**

**Mailing Address:**

**Email Address: Phone:**

**School: Graduation Date:**

**NSNA Membership Number: Cumulative GPA:**

Additional Requirements

Please attach a one-page essay with **brief description about your eligibility to receive the award** (See criteria above)

Terms and Agreement

I certify that all statements made in this application are complete and accurate. I understand that: (1) Falsification in my application or attachments will disqualify my application. (2) Failure to follow all instructions of this application will render my application incomplete. (3) If I am selected as a scholarship recipient, I agree to release my name, address and telephone number to the scholarship sponsor, *Hawai’i Student Nurses’ Association*. (4) By sending this page with my application, I attest that all of the information is accurate; and (5) By signing this agreement, I give permission to the *Hawai’i Student Nurses’ Association* to request and/or verify information provided in this application and that all Scholarship Committee decisions are final.

Please print name and sign the signature line below.

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

 Print Name Applicant Signature Date

 **DO NOT WRITE BELOW THIS LINE – FOR HISNA USE ONLY**

 Application Complete Date Received:

 Application Incomplete Reviewed By:

Reason for Incomplete Application: