ExceptionalNurse.com awards scholarships of $250.00-$500.00 to qualified students with disabilities to continue their education in a nursing education program. Preference is given to undergraduate students. Applicants must demonstrate a serious commitment to the academic study of nursing and career excellence. This scholarship is not renewable and will only be awarded once.

Eligibility Requirements: Applicants must be students with a documented disability who have applied to, or already been admitted to, a college or university program on a full-time basis.

Checklist:

- Completed and signed application form.
- Three letters of recommendation from individuals who can personally attest to your academic abilities and personal character (these cannot be your relatives).
  - Essay (approximately 1-2 pages).
- Official transcripts of high school and/or college courses completed.
  - Medical Verification of Disability Form.

Applications must be received by June 1. Late, unsigned or incomplete applications will not be considered.

Please mail application and other documents to:

Scholarship Committee
ExceptionalNurse.com
13019 Coastal Circle
Palm Beach Gardens, Fl 33410

www.ExceptionalNurse.com
ExceptionalNurse.com Scholarship Award Application

Information about the applicant:

Name:
Last __________________________ First ____________________ M.I ______

Permanent Address:
Street ___________________________________________ Apt. ______

City __________________________ State ________ Zip Code ______

Date of Birth: ___/___/____ Age: _______ Male_____ Female_____

Citizenship: U.S. _______ Other___________

Home Phone: ______________ Work___________ Cell __________

Email: _______________________

Parent/Guardian

Name:
Last __________________________ First______________________ M.I ______

Permanent Address:
Street ___________________________________________ Apt. ______

City __________________________ State ________ Zip Code ______

Disability: Describe your disability. Please attach the Medical Verification of Disability Form.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
**Education:**

I am currently in my _______ year of high school/college (circle one).

I am currently enrolled in _________________________College/University.

I have been accepted at ___________________________College/University.

I have declared my major as __________________________

I have disclosed my disability to the nursing program. Yes___ No____

I have requested accommodations  Yes_____ No____

If yes, describe the accommodations requested.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

My career goal/objective is:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Educational History:** List all schools you have attended.

Name of School_____________________________City_________________State_____
Date of graduation ______

Name of School_____________________________City_________________State_____
Date of graduation ______

Name of School_____________________________City_________________State_____
Date of graduation ______

Name of School_____________________________City_________________State_____
Date of graduation ______

Name of School_____________________________City_________________State_____
Date of graduation ______
Activities and Honors:

List any honors, recognition and/or awards you have received for your academic work.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

List any school or community activities, or non-academic honors, recognition, and/or awards you have received.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Describe your hobbies, activities and interests not related to school.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Financial Background: (Information will remain confidential)

Father’s occupation: ________________________   Income: _______________
Mother’s occupation: ________________________   Income: _______________
Your occupation: ___________________________   Income: _______________
Spouse’s occupation: ________________________   Income: _______________

List any extenuating circumstance that demonstrate financial need (e.g. medical bills, single parent, parent is disabled).

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
College Applications: Which college/universities are you applying to?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
First choice: ________________________________ Have you been accepted? Yes No
Second choice: ____________________________ Have you been accepted? Yes No
Third choice: ____________________________ Have you been accepted? Yes No

Indicate costs for the above colleges.

First Choice:
Tuition: ____________ Room&Board ____________ Other _______ Total _______

Second Choice:
Tuition: ____________ Room&Board ____________ Other _______ Total _______

Third Choice:
Tuition: ____________ Room&Board ____________ Other _______ Total _______

Other sources of funding: Student: $__________
Family: $_________________________ Employment: $____________________
Scholarships: $__________________ Loans: $____________________

Essay
Please submit an essay on how you plan to contribute to the nursing profession and how
your disability will influence your practice as a nurse. Essays should be 1-2 pages typed.
This essay will become the property of ExceptionalNurse.com.

Agreement

This is to certify that I ____________________________________________ understand the
receipt of an award is contingent on my full-time attendance this coming school year
in a college or university nursing program. If I am a recipient, I give my permission
to ExceptionalNurse.com to release information to the media (with exception of
financial status) and publish all or an excerpt of my essay.

Further, I certify that all information contained in the application is true and
accurate, to the best of my knowledge. I understand that all decisions made by the
Scholarship Committee are final.

Name of applicant (please print) __________________________________________

Signature of applicant __________________________________________ Date _________
Please have your physician or vocational rehabilitation counselor provide the following information. Submit this form with your application.

Name of Patient/Client: ____________________________________________
Address: _________________________________________________________
City: ____________________________________________________________
State: ___________________________ Zip Code_______________________

Verification of Disability

Diagnosis: ________________________________________________________
Prognosis___________________________________________
Recommendations: _______________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Name of Physician/ Nurse Practitioner/Counselor:
_____________________________________________________________________
Address: _____________________________________________________________
City: _________________________________________________________________
State: ___________________________ Zip Code_____________
Phone: ________________________________ Email: __________________________

Print Name: _______________________________________________ Signature: ___________________________ Date: _____________________

Additional comments:
________________________________________________________________________
________________________________________________________________________