South Bay Black Nurses Association, Inc. Scholarship Application

Please Type or Print in Ink

Name_____ Tel. No. ( )_____
Last First Middle/Maiden

Current Address_____ City_____ State_____ Zip code_____

Date of Birth_____ Social Sec. No._____

Place of Employment _____Monthly Salary $_____

Place of Employment (Spouse)_____ Monthly Salary $_____

Head of Household: Father__ Mother__ Self__ Spouse__ Other__

Name of Others You Support	Relationship	Age	School/Place of Employment

Do you currently hold a nursing license? No___ Yes__ License No._____ State___

List Anticipated Source(s) of Income: e.g., family, scholarship, grant, loans, veterans benefits

_____

Name of nursing program in which enrolled_____
Nursing program must be accredited

Address_____

City_____ State_____ Zip Code_____

Dean/Director_____ Telephone no. ( )_____

Classification_____ Expected Graduation Date _____Advisor_____

Extracurricular/Community Activities (you may attach an additional sheet if necessary)

_____

_____

I hereby affirm that all the information provided is true. Any false statement will forfeit the award.

Signature_____ _____Date_____

SBBNA Student Member: Yes___ No____

Rev. July 2010