

Applicant's Name \_\_\_\_\_

Please Print

## **Community Nursing Service Health and Education Foundation**

### **Healthcare Scholarship Re-Application Form**

Re-application for the Community Nursing Service Health Care Scholarship is required for all scholarship recipients. This process was established to review the applicant's progress in school, as well as the career progress and intentions of the student to maintain a health care major

#### Guidelines for Re-Applicants:

- Student must maintain an adequate GPA in a health care major
- Any changes in educational institutions or major **MUST** be reported to the scholarship chairman prior to June 1<sup>st</sup> of each year. Contact Chrissy Pearson at 724-972-1974 or [Chrissy@cns scholarship.com](mailto:Chrissy@cns scholarship.com)
- Fill out the form below and sign the last page
- Attach a copy of your most recent college transcript

**The complete application must be mailed/emailed/submitted no  
later than **March 15****

Applications may be mailed to:

CNS Health and Education Foundation  
Chrissy Pearson, Scholarship Chairman  
3040 Williamsburg Lane, #4  
Latrobe, PA 15650

Applications may be emailed to:

[Chrissy@cns scholarship.com](mailto:Chrissy@cns scholarship.com)

Or submitted online:

[https://www.cns scholarship.com/submit-  
application](https://www.cns scholarship.com/submit-application)

# CNS Health and Education Foundation Scholarship Re-Application Form

## General Information

Applicant's Birthdate: \_\_\_\_\_ Renewal of scholarship for year: 2 3 4 \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

**Home** Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Parent(s)/Guardian(s) Full Name \_\_\_\_\_

**School** Address: \_\_\_\_\_

Apt. or Dorm #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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## School Information

GPA: \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

Student's Personal School ID: \_\_\_\_\_

University/College Name: \_\_\_\_\_

Address: \_\_\_\_\_

Major/Field of Study: \_\_\_\_\_

# CNS Health and Education Foundation Scholarship Re-Application Form

## Financial Data

Est. Yearly <u>Cost</u> to Attend School		Yearly <u>Income</u> to Meet Costs	
Tuition:	\$	S.S. Allowance (if any):	\$
Room and Board:	\$	V.A. Allowance (if any):	\$
Books:	\$	Family Contribution:	\$
Transportation: (To and from home, holidays)	\$	Student Contribution: (Work, Savings, etc.)	\$
Other Significant Personal Expenses: (Uniforms, professional fees, etc.)		List of All Other Financial Aid: (Pell Grant, Merit Scholarship, Presidential/Chancellor, All student loans, Other scholarships)	
	\$		\$
	\$		\$
	\$		\$
	\$		\$
	\$		\$
	\$		\$
	\$		\$
<b>Total Est. Cost:</b>	<b>\$</b>	<b>Total Est. Income:</b>	<b>\$</b>

Comments: (Optional)

Any conditions, explanations, or additional information relative to changes in your economic or academic status

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**CNS Health and Education Foundation Scholarship  
Re-Application Form**

I certify that the information on this application is correct. I fully understand the guidelines for the re-application process and have abided by these guidelines. In addition, I fully understand that the Board of Directors of Community Nursing Service in Greensburg, Inc. retains total and complete control of any award determinations, and the re-selection process will be based on maintaining an adequate QPA average and a health care major. Judges will not discriminate based on race, color, age, sex, or disease entity. The decisions regarding the scholarship awards are final.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_