LSU Health Sciences Center
NEW ORLEANS
School of Nursing

Career Alternative Registered Nurse Education (CARE) Program
APPLICATION FOR SCHOLARSHIP

Legal Name _____
Last First Middle

Address _____
Number and Street Apartment City State Zip

Telephone Number: Home _____ Cell: _____

Email: _____

Date of Birth: _____/_____/_____ Place of Birth: _____
Month Day Year City State

Citizen or permanent resident of the United States: Yes ☐ No ☐

Sex: Female ☐ Male ☐ Social Security Number: _____-_____-_____

The LSU Health Science Center School of Nursing must indicate it is in compliance with Title IV of the Civil Rights Act. Please indicate which ethnic group best describes you:

☐ African-American ☐ Asian or Pacific Islander (please specify) _____

☐ American Indian or Alaskan Native

☐ Hispanic ☐ White (Not of Hispanic Origin) ☐ Other _____

Married ☐ Single ☐ Single Parent ☐

How many persons, besides yourself, are you financially responsible for? _____

List names, relationship and ages of all persons you are financially responsible for:

NAME	RELATIONSHIP	AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you a first generation college student in your family? Yes ☐ No ☐

Upon graduation, do you intend to work in a medically needy or underserved area of the United States?

☐ Yes If yes, where: _____ No ☐

By signing below, I understand that LSUHSC School of Nursing will receive financial aid information from the Financial Aid Office of LSUHSC. I also understand that requests from the school of nursing for more financial information may be necessary for determination of scholarship funds.

_____ _____ _____
Print Name **Signature** **Date**

8/08 SP