South Plains Nurse Practitioners Association

Nurse Practitioner Scholarship
Master of Science in Nursing, Student

Please submit to: SouthPlainsNPAssociation@gmail.com

APPLICATION DEADLINE: 10/10/2023

The Nomination Committee will give weight to the following criteria for the application:

1. Currently enrolled in a nurse practitioner program with good academic standing.
2. Likely to reside and practice within the South Plains Nurse Practitioners Association area or the West Texas area after graduation.
3. Must be an active student member of SPNPA and must have attended at least two SPNPA meetings in the last twelve months.
4. Expected or scheduled to complete his/her NP education within one year of receiving the award.
5. Professional goals working as a nurse practitioner.
6. How the scholarship might benefit the student.

Scholarship definition:

1. The scholarships are awarded by the South Plains Nurse Practitioners Association (SPNPA) which is a nonprofit organization. The scholarship is a one time award which is neither ongoing nor renewable. A recipient may only receive the award one time. The amount of the award for 2023 will be $500.00 and there will be 2 scholarships awarded. The awarded amount and number of scholarships may change, as determined by SPNPA on an annual basis. Delivery of the award to school or recipient will be arranged by the SPNPA Scholarship Committee or Executive Board.

2. Student selection for each scholarship is at the discretion of the Scholarship Committee of the SPNPA and the decision will be final.

3. Award presentation date: October 17, 2023.

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Personal Information

Name: _____

Social Security Number (last 4 digits): _____

Mailing Address: _____

City, State and Zip Code: _____

Phone Number: _____ Date of Birth: _____

E-Mail Address: _____

Expected date of completion of Nurse Practitioner program _____

Do you intend to practice in the West Texas area upon graduation? Yes ___ No ___

If Yes, What County in West Texas? _____

Have you attended two of the South Plains Nurse Practitioner Meetings in the year? _____

Are you a member of the South Plains Nurse Practitioner Association? _____

Contact person and phone number to verify academic standing? _____

Permission to verify scholastic standing where I am enrolled by signing below.

_____

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Instructions:

1. All responses must be typed**.** Handwritten responses will not be considered for scholarship awards.

2. Read all instructions and scholarship definitions.

Please describe in the space below your professional goals as a Nurse Practitioner in the West Texas area. (Limit to 100 words)

How will the scholarship benefit you? Please add any other information about yourself, your family, or your circumstances that you think should be considered by those reviewing your application. Include information that can be shared with the SPNPA membership in the event you are selected to receive this scholarship. (Limit to 50 words)

RELEASE: I understand that the information I provide must be complete and accurate in order to be considered. Failure to provide complete and accurate information will result in my application(s) being disqualified from consideration. I also understand that all information submitted in the application process becomes the property of the SPNPA and will not be returned. I further understand that it is my responsibility to submit the required documentation as stated on the SCHOLARSHIP INFORMATION SHEET. Failure to submit proper documentation may result in the disqualification of my application(s).

_____
Written or Electronic Signature of Applicant

"I hereby give South Plains Nurse Practitioners Association permission to use the information provided on this application for recognition purposes if I accept this designated scholarship." ____Yes ____No

_____
Signature of Applicant

"I authorize the South Plains Nurse Practitioners Association to release information concerning my records to federal, state, institutional, or local organizations/agencies as is necessary for the administration of my scholarship. I understand this authorization will remain in effect unless revoked in writing. ____Yes ____No

_____
Signature of Applicant

DATE _____