

**Nursing Scholarship**

**Daviess Community Hospital is committed to improving the health of the people who live in our communities by providing excellent medical care, ensuring access to that care, teaching healthy lifestyles, and working with local agencies to meet community health needs. In keeping with our mission, DCH supports the growth and development of current and future nurses.**

# What is the Daviess Community Hospital Foundation Nursing Scholarship?

* The vision of the scholarship program is to identify a selected number of future nursing professionals to promote the profession of nursing and cultivate future nursing leaders within our community.
* The nursing scholarship is funded by the Daviess Community Hospital Foundation and payable to the applicants’ school. The scholarship allows recipients to utilize the funds at their discretion to support their successful completion of their degree from an accredited school of nursing.
* This is a unique opportunity for nursing students that begins in their final year of nursing education. The scholarship is intended to support future nursing professionals as they achieve their educational objectives, nursing licensure, and career goals in nursing at DCH.

# What are the requirements of the scholarship program?

* Interested applicants must be entering their final year of nursing education, and must be in good standing with an accredited school of nursing.
* The scholarship candidate will, at the time of application, have a GPA of 3.2 or higher.
* The scholarship candidate will need to be currently enrolled in their last year and be eligible to take the NCLEX exam upon completion of nursing courses.
* Students will apply for a nursing position with DCH their last semester of school.
* As part of the program, the future nursing professional must sign an agreement to remain employed at DCH as a Registered Nurse in a direct patient care area full time for a period of two (2) years.
* If separation of employment occurs before the 2-year obligation is met, the entire scholarship amount must be repaid to Daviess Community Hospital Foundation. A Student Commitment Agreement is required to be signed by the recipient.

# What are the scholarship benefits?

* An amount of $5,000.00, granted to each scholarship recipient to assist with successful completion of his/her nursing curriculum.
* Full time Nursing position at DCH focusing on critical shortage areas.
* Individualized nursing orientation and unit orientation with preceptor.
* Post-employment opportunities for specialty certification and ongoing continuing education.
* Opportunity to participate in the DCH Nurse Onboarding.



**NURSING SCHOLARSHIP**

**TYPE OR PRINT ALL INFORMATION**

Completeness and neatness ensure your application will be reviewed properly.

**APPLICATION POSTMARK DEADLINE IS: March 4, 2024**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **APPLICANT**  **DATA** | Last Name |  | First Name | Middle Initial |
|  | Permanent home mailing address |  |  |  |
|  | City |  | State | Zip Code |
|  | Phone |  | E-mail Address |  |
|  | Nursing Program/School |  | Anticipated graduation | month and year |

If space provided in any section is inadequate, you may continue on additional sheets of paper using the same format.

DO NOT repeat information already reported on the application form. Your name, address and name of this scholarship program

should be included on all attachments.

The student is responsible for submitting all materials to DCH Human Resources by identified time frames. Incomplete applications will not be evaluated. This application becomes complete and valid only when DCH Human Resources has received all of the following materials:

**APPLICATION CHECKLIST**

Student Application (this packet must be submitted on line or emailed). Emailed to: Heather Stone at Hstone@dchosp.org

Mailed to:

**Human Resources** - **Daviess Community Hospital Foundation Nursing Scholarship**

**1314 East Walnut Street Washington, IN 47501 Attention: Heather Stone**

Current official transcript

(can be mailed or electronically requested).

Student Clinical Performance Evaluation Form

(Last page of application, form must be signed by student and sent to instructor).

**WORK EXPERIENCE**

List your work experience during the past four years. Indicate dates of employment for each job and approximate number of hours worked each week.

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| --- | --- | --- | --- | --- | --- |
| Present or Last Employer |  |  |  | Phone (including area code) |  |
| Address  Name While Employed |  | City  Job Title |  | State Start Date  Supervisor’s Name | Zip  End Date |
| Summary of Duties |  |  |  |  |  |
| Reason for Leaving |  |  |  |  |  |
| Present or Last Employer |  |  |  | Phone (including area code) |  |
| Address |  | City |  | State | Zip |
| Name While Employed |  | Job Title |  | Start Date | End Date |
|  |  |  |  | Supervisor’s Name |  |
| Summary of Duties |  |  |  |  |  |
| Reason for Leaving |  |  |  |  |  |

**ACTIVITIES, AWARDS AND HONORS**

List all school activities in which you have participated during the past four years (e.g. student government, music, etc.) List all community activities in which you have participated without pay during the past four years (e.g. Boy/Girl Scouts, hospital volunteer). Note all special awards, honors, and offices held. Indicate whether high school or college activities.

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| --- | --- | --- | --- |
| Activity | Number of Years Participation | Special Awards, Honors | Offices Held |
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**GOALS AND ASPIRATIONS**

Provide a statement or summary of your plans as they relate to your educational and career objectives and long- term goals. (Please attach a separate page if additional space is needed.)

**DISTINGUISHING QUALITIES**

Please describe any characteristics about yourself that you feel distinguish you from your peers. Please do not repeat information that is included elsewhere in this application.

**TRANSCRIPT INFORMATION**

An official transcript of grades must be sent with this application.

Mailed

Sent Online

Must be official, can be mailed or sent online by electronically requesting an eTrancript.

Mailed Transcripts should be addressed to:

**Human Resources** - **Daviess Community Hospital Foundation Nursing Scholarship**

**Attn: Vianna Hastie**

**1314 East Walnut Street Washington, IN 47501**

Online transcripts must be ordered to be sent to Vianna Hastie at VHastie@dchosp.org

**BACKGROUND**

Have you ever been convicted of a crime, excluding minor traffic violations? □ Yes □ No If yes, please list the conviction date, court, location and type of the offense.

**Please read and sign**

I voluntarily authorize Daviess Community Hospital (DCH) to make a thorough pre-employment investigation, including a limited criminal history background check for the purpose of qualifying for a DCH Foundation Nursing Scholarship. I understand that I have the right to obtain a copy of that report at my own expense and to challenge any information that I believe to be inaccurate. I hereby authorize former and present employers and others to provide or verify any information they have regarding my employment or me and release them from any liability for furnishing such information to DCH. I understand that scholarship qualification and employment is contingent on satisfactory outcomes of reference and background checks. The information in this document that I have provided is true and complete, and I have met the eligibility requirements of the program as described. False statements on this scholarship application and employment-related documents shall be considered sufficient cause for denial of scholarship qualification. Falsification of information may result in termination of any scholarship granted upon discovery of such falsification. If I receive a DCH Foundation Nursing Scholarship and an offer for employment, I agree to have a medical evaluation and understand that any subsequent employment is contingent upon passing that evaluation. As an employee, I agree to take such future medical evaluation as may be lawfully required by DCH. If I am employed, I understand that I may be required to work weekends, holidays and overtime and hereby agree to do so. I agree to accept a temporary shift or unit change whenever emergency conditions warrant. If employed, I agree to abide by the policies, procedures and rules of DCH and the department to which I am assigned. I further agree to protect the confidentiality and privacy of any information regarding DCH and its patients. I acknowledge that decisions of DCH and its Selection Committee are final. This application and its attachments become the property of DCH. (It is recommended that you keep a copy for your files.)

Applicant’s Signature for Daviess Community Hospital Foundation Nursing Scholarship Program and Employment Application Records

Date

# STUDENT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize you and your institution to provide the information requested and release you and your institution from any liability resulting therefrom. All information provided to Daviess Community Hospital will be held in confidence and used for the specific purpose of the Nurse Intern Application process.

Student Name (please print)

Student Signature Date

# STUDENT PERFORMANCE EVALUATION

(to be completed by nursing faculty)

School of Nursing Instructor

Please use a scale of 1 to 5 (1 = Unsatisfactory, 5 = Excellent) to rate the student on the following performance criteria:

Attendance

Initiative

Quality of Work

Attitude

Team Work

Organizational Skills

Integrity

Cooperation

Relationship with Others

Communication Skills

Comments/Strengths/Areas for Improvement:

I would recommend this student for the Daviess Community Hospital Foundation Nursing Scholarship:

Yes No

If no, why not:

Faculty Signature Date

Printed Name

**\*Submit this release of information and evaluation form to:**

Human Resources, Attn. Vianna Hastie Daviess Community Hospital

1314 East Walnut Street Washington, IN 47501

OR via email to: Vianna Hastie at VHastie@dchosp.org

If you have any questions, please contact Human Resources at 812-254-2760.