FNF
FLORIDA NURSES FOUNDATION

For blind review, enter the last four digits of applicant's SSN in this box

Florida Nurses Foundation
Research Grant Face Sheet

First Name: _____ Last Name: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

County of Residence: _____ Region of State: ❑North ❑South ❑Central ❑East ❑West

College/University: _____

County of College/Univ: _____ Region of State: ❑North ❑South ❑Central ❑East ❑West

Email*: _____ Best Phone: _____

Title of Project: _____

Principal Investigator and Co-Investigators (if applicable): _____

_____

Research Funding for this Project Received to Date: _____

Source of Funding: _____

**Email is required – most communication regarding scholarships are done via email*

Application Agreement

(Signature Required)

Please initial by the statements you agree with and sign at the bottom.

Scholarship Funds and Follow-Up

_____Should I be awarded funds and withdraw from my nursing program before completing the semester/year for which this scholarship applies, or discontinue the study at my institution I pledge to repay to Florida Nurses Foundation the sum advanced. **(REQUIRED)**

_____Should I be awarded funds, I agree to participate for up to three years of follow-up allowing the Foundation to check on the status of my educational progress. **(REQUIRED)**

Publication of Name and Image Preference (Select One)

_____I agree that my name and image may be used for public relations purposes (e.g., Florida Nurses Association and Florida Nurses Foundation publications, press releases to news media).

_____I would prefer that my name **not be** used for public relations purposes.

This will not affect the scoring of your scholarship application.

Signature: _____ Date: _____