

Florida Nurses Foundation Scholarship Application Personal ID Form

First Name: _____ Last Name: _____

Street Address: _____

City: _____ Zip: _____ County of Residence: _____

College/University: _____ County of College/Univ: _____

Email*: _____ Best Phone: _____

**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, 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: _____