

# Trinity College of Nursing and Health Sciences Scholarship Application

**Please complete each item below:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ / \_\_\_\_\_ - \_\_\_\_\_  
(Last Name, First Name, Middle Initial)

Current Address: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(Street Address) (City) (State) (Zip Code)

Permanent (Former) Hometown \_\_\_\_\_ Hometown Newspaper \_\_\_\_\_  
(City, State)

E-mail Address \_\_\_\_\_

I have registered (plan to register) for \_\_\_\_\_\* credit hours.  
 Current GPA: \_\_\_\_\_\*  
 \*Important information, do not omit.

## I am a student in:

	Year (1-4)	Semester (1-2)
<input type="checkbox"/> Nursing-ASN	_____	_____
<input type="checkbox"/> Nursing-(circle one) BSN-A, BSN-B, BSN-C	_____	_____
<input type="checkbox"/> Radiography	_____	_____
<input type="checkbox"/> Respiratory Care	_____	_____

**Please list other financial or gift assistance you are currently receiving:**

## ALUMNI SCHOLARSHIP (only complete if you are an alumnus requesting funds for continuing or higher education)

**I am a dues-paying member of Trinity College Alumni Association.  yes  no**

Program of Study \_\_\_\_\_ Year of Graduation: \_\_\_\_\_  
 Current College Attending \_\_\_\_\_ Hours Completed: \_\_\_\_\_  
 Other Post Secondary Education: \_\_\_\_\_ Degrees Attained: \_\_\_\_\_

(The following information is optional and will not affect your scholarship eligibility.)

Are you employed by Trinity Regional Health System?  yes  no  
 If yes, campus \_\_\_\_\_ department \_\_\_\_\_ position \_\_\_\_\_  
 Are you currently receiving scholarship assistance from other sources?  yes  no  
 If yes, from where / whom (community, state or national organization)? \_\_\_\_\_

**All Applicants: PLEASE ATTACH TO THE APPLICATION FORM a brief statement of your educational and professional goals and personal/financial need for scholarship assistance in support of your application.**

**Submit completed application form and above requirements**

To: Trinity College  
 2122 25<sup>th</sup> Ave.  
 Rock Island IL 61201

If you have any questions, please call the Student Services Office at:  
 (309) 779-7700

I confirm that the information on this application is accurate and do hereby agree to notify Trinity College of Nursing and Health Sciences Schools of any change. I also authorize Trinity College of Nursing and Health Sciences Schools to release academic and financial aid information to the Trinity College Scholarship Committee.

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

## FOR OFFICE USE ONLY

Date Received \_\_\_\_\_  
 Narrative Yes\_\_\_ No\_\_\_  
 Scholarship Awarded Yes\_\_\_ No\_\_\_  
 Scholarship \_\_\_\_\_  
 Amount \_\_\_\_\_  
 Account Number \_\_\_\_\_  
 Student ID Number # \_\_\_\_\_