Debbie Daehn Nursing Memorial Scholarship

Name ________________________________

Mailing Address ________________________

City ____________________________

State ___________________________

Zip Code ________________________

Phone number _________________________

Email Address __________________________

Employer __________________________

Position/Title_______________________

Department ________________________

Employee ID (if SPH) ________________

Hours per week/FTE ________________

Retraining for a new SPH Job? ________

Please describe your professional work experiences:
(Example - I worked at St. Peter's Health, Helena, MT from 6/1998 through 8/2001):
____
____
____

I am currently employed at ________ St. Peter's Health _______ Lewis & Clark County Public Health

Name of School or Program ____
Mailing address for Business Office or Financial Aid (Where you want the check sent)
____

*To explain the amount of financial support requested please complete the Estimated Itemization of School Expenses on the reverse

Please write a short paragraph about your Education Plan: (What education, certifications, or degree you are seeking and how it supports your educational and professional goals. No more than 500 words please)
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____
____
____
____
____
____

I hereby certify that the information set forth in this application is true and complete.

Applicant Signature ____ Date ____________

Printed Name ____

Itemization of Estimated School Expenses

Item	Description/Detail
Tuition	
Course Registration	
Fees	
Supplies (books, other educational materials)	
Equipment	
Travel	
Lodging	
Cost of Living Expense	
Other	
Total Budget:	
Amount Requested:	