Dianne Armstrong Endowed Scholarship for Future Nurses

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)
_____
_____
_____
_____
_____
_____
_____

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:	