JACK D. WILSON NURSES TRAINING
TRUST FUND
TO PROMOTE REGISTERED NURSING

APPLICANT INFORMATION

Name_____

Address_____ Picture

Post Office_____

Date of Birth_____

U.S. Citizen _____Yes _____No

Marital Status_____

Home Telephone_____

LIST BELOW ANY DEPENDENTS OF THE APPLICANT

Name	Age	Relationship
_____	____	_____
_____	____	_____

Parents or Guardian _____

Address _____

City _____ State _____ Zip _____

LIST BELOW ALL DEPENDENTS OF PARENTS OR GUARDIAN

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST THREE PERSONS IN YOUR COMMUNITY AS REFERENCES

Name	Address
_____	_____
_____	_____
_____	_____

WHO FIRST SUGGESTED THAT YOU APPLY TO THIS TRUST FUND

Name_____ Address _____

City_____ State_____ Zip_____

I AM BEING RECOMMENDED BY:

Voiture locale No. _____ Of _____ County.

ADDRESS OF THE ABOVE RECOMMENDING VOITURE:

Address_____

City_____ State _____Zip_____

EDUCATIONAL INFORMATION

High School	Address	Dates Of Attendance
_____	_____	_____
_____	_____	_____

(IMPORTANT) ATTACH A TRANSCRIPT OF YOUR SCHOOL RECORD TO INDICATE YOUR ACHIEVEMENT LEVEL AND GENERAL APTITUDE:

WHAT INSTITUTION ARE YOU ATTENDING:

Institution	Department	Director
_____	_____	_____

Address _____

City_____ **State**_____ **ZIP**_____

HAVE YOU APPLIED OR DO YOU INTEND TO APPLY FOR OTHER SCHOLARSHIPS, FELLOWSHIPS, GRANTS, ETC., ___YES ___NO.

IF YES, PLEASE EXPLAIN _____

_____

_____

_____

_____

IMPORTANT:

Tell us about your plans for your future professional career. Include your reasons for choosing Nursing. _____

_____

_____

_____

_____

FINANICAL INFORMATION

Annual Income of Applicant_____

Occupation (s) of Parent (s) _____
_____

EXPLAIN BRIEFLY WHY YOU ARE IN NEED OF ASSISTANCE

_____
_____
_____
_____

ADVISE WHEN IT IS CONVENIENT FOR ADDITIONAL DISCUSSION, IF IT IS FOUND NECESSARY.

_____

IF I AM GRANTED AID, I HEREBY CERTIFY THAT:

I am in need of the aid in order to continue my education to become a Registered Nurse. I will not be receiving aid or financial support from another

40 et 8 NURSES TRAINING PROGRAM or FUND during the same period of time that I am receiving aid from the JACK D. WILSON NURSES TRAINING FUND. I am properly enrolled as defined by the office of the register.

I will use the aid for tuition, fees, room & board (dormitory), and other school related expenses.

I hereby acknowledge that the information submitted on this application is true and correct.

DATE _____ SIGNATURE _____

PARENTS OR GUARDIAN STATEMENT:

To the best of my knowledge, the information reported is complete and correct.

I understand that _____ is applying for financial aid

to help with educational expenses at _____

School of Nursing located in _____

DATE _____ SIGNATURE _____

SCHOOL OF NURSING STATEMENT

It is understood and agreed to by the _____

School of Nursing that any funds granted to applicant _____
by the **JACK D. WILSON NURSES TRAINING TRUST FUND** shall be made
Payable to the above named institution thru the student. During the period of assistance, the **STUDENT** will keep The Wilson Trust Fund Committee advised of the student's general progress for purposes of continued consideration by The Wilson Fund Committee. If the student begins to fail or drop out, the applicant will immediately notify the Trust Fund Committee. Failure to do so may cause disqualification of the applicant. The above named institution does believe that the applicant has the ability and qualifications to pursue the intended career and become a Registered Nurse.

DATE_____SIGNATURE _____
Director of Nursing Administrator

RETURN OF APPLICATION

Give this form, when filled out to your recommending Voiture Locale member who will then send it along with their cover letter to.

GRAND VOITURE DE WISCONSIN
DIRECTEUR NURSES TRAINING

Doug Schaller
317 N. Van Ness St.
West Salem, WI. 54669-1203
608-385-6812