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 ___________________________________

____

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____

____

IMPORTANT:

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

____

____

____

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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

Dale Mitchell Cell 262-949-3150
N9470 Haltur Lane
Eagle, WI 53119