

**Mildred H. Smith Foundation, Inc.**



**SCHOLARSHIP FOR CONTINUING EDUCATION  
APPLICATION INFORMATION**

Purpose

To be given to an LPN for the purpose of attending one continuing education program per two year licensure period.

Criteria

- ✓ Applicant must have been an LPN for at least 5 years;
- ✓ Applicant must hold a current valid license as an LPN in Ohio;
- ✓ Applicant must indicate in essay format how attendance at the proposed educational activity will enhance their practice as an LPN;
- ✓ Applicant has not received funding from the MHSF for a continuing education program in the past 24 months;
- ✓ The amount awarded will cover not more than 80% of the program registration fees;
- ✓ The program to be attended and for which financial assistance is being sought must be approved for continuing education through an Ohio Board of Nursing Approver Unit;
- ✓ Preference will be given to those making application to attend a MHSF sponsored program; and
- ✓ Applicant must show proof of having successfully completed the specific program for which application was made.

Application Process

Applicant must submit the completed application form for scholarship request no later than 60 days prior to date of the specific educational program.

A copy of the program brochure or advertisement that includes the program title, date of program, times offered, program objectives, continuing education approval statement, and costs, must accompany the completed scholarship application.

If the application form is received incomplete, additional information may be requested by the MHSF administrator. Please bear in mind that any such request for additional information may slow the decision making process and result in the applicant missing the intended program.

Failure to successfully complete the specific educational program for which the scholarship is being requested may result in denial of similar funding requests in the future.

The completed application form will be reviewed by 2 members of the MHSF Scholarship Committee. A decision will be communicated to the applicant in writing via mail within 30 days of receipt of the completed scholarship application. Payment of the program registration fee will be made directly to the program for which funding is being sought.

**SCHOLARSHIP FOR CONTINUING EDUCATION  
APPLICATION FORM**

**I. Complete all requested information. Print or Type**

Name (First) \_\_\_\_\_ (Last) \_\_\_\_\_

**Mailing Address**

**(Street)** \_\_\_\_\_ **(Apt)** \_\_\_\_\_  
**(City)** \_\_\_\_\_ **(State)** \_\_\_\_\_ **(ZIP)** \_\_\_\_\_ - \_\_\_\_\_

**Ohio Nursing License Number** \_\_\_\_\_ **Social Security Number** \_\_\_\_\_

**Area of practice** \_\_\_\_\_

**II. Program Information**

**Title of program for which funding is being sought**

\_\_\_\_\_

**Program Sponsor** \_\_\_\_\_

**Address to which registration is to be sent**

**(Street)** \_\_\_\_\_ **(Apt)** \_\_\_\_\_  
**(City)** \_\_\_\_\_ **(State)** \_\_\_\_\_ **(ZIP)** \_\_\_\_\_ - \_\_\_\_\_

**Date of Program** \_\_\_\_\_

**Number of Contact hours to be awarded upon successful completion** \_\_\_\_\_

**Cost of Registration** \_\_\_\_\_

\_\_\_\_\_ **Copy of program brochure or advertising is attached.**

**III. In the space provided, explain how completion of this program will enhance your nursing practice and help individuals to whom you deliver nursing care.**

**IV. All required information is complete and accurate to my knowledge. If funding is granted for the above mentioned program, I will be responsible for payment of 20% of the program fees, payment will be provided directly to the program sponsor by the Mildred H. Smith Foundation, Inc., and I will be required to submit a copy of my certificate of completion to the Mildred H. Smith Foundation, Inc., within 30 days of program completion, as proof of successful completion of this program. I further understand, that should funding be awarded as requested and I not complete this program successfully, future requests for similar funding may be denied and if payment has already been sent to the program sponsor, I will be responsible for reimbursement of the full amount paid by the Mildred H. Smith Foundation, Inc.**

\_\_\_\_\_/\_\_\_\_\_  
**Signature** **Date**