

ODONA/LTC
LPN to RN SCHOLARSHIP
APPLICATION

Complete entire form. Please print or type.

Name: _____ Social Security # _____

Home Address: _____

City _____ State: _____ Zip: _____

County _____ Home Phone # _____

Employer _____

Address _____ City _____

Work Phone (____) _____ Number of years employed _____

Email address _____

Name of DON _____

Is your DON a current member of ODONA? Yes _____ No _____

Applicant must have been working in long term care for at least one year.
Please give evidence of how you have met this requirement.

Please provide a narrative of at least 100 words as to why you wish to become an RN and be considered for a scholarship award, and how it will impact your practice. You may attach additional pages as needed.

I understand that this application for an ODONA LPN to RN Scholarship will be given to the ODONA Scholarship Committee, which has the authority to accept or reject this application.

Applicant Signature _____ Date _____

Please mail completed application and Recommendation Forms to:
ODONA/LTC
626 Amber Drive
Zanesville, Ohio 43701

ODONA/LTC
LPN to RN SCHOLARSHIP
RECOMMENDATION FORM

This copy must be completed by applicant's DIRECTOR OF NURSING

Name of Applicant: _____

Name of Director of Nursing: _____

Facility: _____

Telephone number of DON: (____) _____ Email _____

Are you a member of ODONA? _____

How long have you known the applicant? _____

How would you rate the applicant on the following? (Please circle appropriate number)

	Low		Average		High
Maturity	1	2	3	4	5
Ability to communicate	1	2	3	4	5
Commitment to long term care	1	2	3	4	5
Leadership	1	2	3	4	5
Sensitivity to Resident Needs	1	2	3	4	5

Comments: _____

How long has the applicant been employed at the facility? _____

Briefly, describe why this applicant would be a worthy recipient of this scholarship (You may attach additional pages as necessary):

Signature _____ Date _____

Director of Nursing: This form must accompany the Application Form and the additional Recommendation Form.

ODONA/LTC
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SECOND RECOMMENDATION FORM

Note: Applicant must have two (2) references: one from the DON (see other Recommendation Form), and this one from a second reference.

Name of Applicant: _____

Name of Second Reference: _____

Facility: _____

Telephone number of Second Reference: _____ Email _____

How long have you known the applicant? _____

How would you rate the applicant on the following? (Please circle appropriate number.)

	Low		Average		High
Maturity	1	2	3	4	5
Ability to communicate	1	2	3	4	5
Commitment to long term care	1	2	3	4	5
Leadership	1	2	3	4	5
Sensitivity to Resident Needs	1	2	3	4	5

Comments: _____

How long has the applicant been employed at the facility? _____

Briefly, describe why this applicant would be a worthy recipient of this scholarship. You may attached additional pages as needed.

Signature _____ Date _____

Second Reference: This form must accompany the Application Form and the Recommendation Form from the DON.