

ODONA/LTC
NURSING ASSISTANT SCHOLARSHIP APPLICATION
Complete entire form. Please print or type.

Name: _____ Social Security # _____

Home Address: _____

City _____ State: _____ Zip: _____

County _____ Phone # _____

Employer _____

Address _____

City _____ State: _____ Zip: _____

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 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 Nursing Assistant 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
NURSING ASSISTANT SCHOLARSHIP
RECOMMENDATION FORM

This copy to 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
NURSING ASSISTANT SCHOLARSHIP
SECOND RECOMMENDATION FORM

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

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 attach additional pages as needed.

Signature _____ Date _____

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