

## **ODONA/LTC NURSING ASSISTANT SCHOLARSHIP**

The ODONA/LTC NURSING ASSISTANT SCHOLARSHIP is awarded to a State Tested Nursing Assistant enrolled in a nursing program in the state of Ohio. The applicant must have been working in long term care for at least one year, and currently be employed at a facility where the DON or ADON is a current member of ODONA. Two (2) recommendation forms (provided) are required: one from the Director of Nursing at the facility where the applicant is employed, and one from an additional reference. Each application must also be accompanied by a letter from your school of nursing verifying your enrollment.

One scholarship in each of the state's five regions may be awarded. All completed applications (including recommendation forms and enrollment verification letter) received by February 1st are considered. Award winners are notified in February and the award is presented in March.

The completed Application, both Recommendation Forms, and enrollment verification letter must be submitted together and received at the ODONA Office by February 1st.

Please mail to:

ODONA/LTC  
190 East Pacemont Road  
Columbus, OH 43202

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

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_

County \_\_\_\_\_ Zip \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Number of years employed \_\_\_\_\_

Email address \_\_\_\_\_

Name of DON \_\_\_\_\_

Is 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.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*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**  
**190 East Pacemont Road**  
**Columbus, OH 43202**

**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 \_\_\_\_\_**

**How long have you known the applicant?** \_\_\_\_\_

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

	Low	Average			High
<b>Maturity</b>	1	2	3	4	5
<b>Ability to communicate</b>	1	2	3	4	5
<b>Commitment to long term care</b>	1	2	3	4	5
<b>Leadership</b>	1	2	3	4	5
<b>Sensitivity to Resident Needs</b>	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:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

*Director of Nursing: This form must accompany the Application Form and the additional Recommendation Form (from the reference) when mailing.*

**ODONA/LTC  
NURSING ASSISTANT SCHOLARSHIP  
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: \_\_\_\_\_

Facility where Applicant is Employed \_\_\_\_\_

Name of Reference: \_\_\_\_\_

Title of Reference: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Telephone Number of Reference:(\_\_\_\_) \_\_\_\_\_

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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

*This form must accompany the Application Form and the additional Recommendation Form (from the DON) when mailing.*