

## **The ODONA/LTC SCHOLARSHIP**

The ODONA SCHOLARSHIP is awarded to current ODONA members (Directors of Nursing and Assistant Directors of Nursing) who have been working in Long Term Care for a minimum of one year. All completed applications, accompanied by a "verification of enrollment" letter from your school of nursing, and received by February 1st, will be considered. Award winners are notified in February and the awards are presented at the annual ODONA Convention in March.

The scholarships are intended to support the mission of ODONA in assisting members in continuing formal education. The scholarship must be used for education related to the role of the Director of Nursing. ODONA awards one scholarship in each of the state's five regions. Your application including the verification of enrollment letter from your school of nursing must be received at the ODONA Office by February 1st.

Please mail to:  
ODONA/LTC  
190 East Pacemont Road  
Columbus, OH 43202

## ODONA/LTC Scholarship Application

**Complete entire form.** Award winners are notified in February. Awards are presented at the ODONA Convention. All completed applications received by February 1st are considered.

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

Home Address: \_\_\_\_\_  
\_\_\_\_\_ Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_ Work Phone: \_\_\_\_\_

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

Current Position: \_\_\_\_\_

I have been (past or present) DON or ADON for \_\_\_\_\_ (# years or months)

I am currently an active member of ODONA. \_\_\_\_\_ Yes \_\_\_\_\_ no

I am active in a local DON Association. \_\_\_\_\_ Yes \_\_\_\_\_ no

Association Name \_\_\_\_\_

Have you ever received an ODONA scholarship? Yes \_\_\_\_\_ no \_\_\_\_\_ if yes, enter year \_\_\_\_\_

Have you attended the ODONA convention? Yes \_\_\_\_\_ no \_\_\_\_\_ If yes, list year (s) \_\_\_\_\_

Applicants must have been working in Long Term Care for at least 1 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.

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

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

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

Please mail the completed application to: ODONA LTC  
NOTE: ODONA must receive by 190 East Pacemont Road  
February 1<sup>st</sup>. Columbus, OH 43202