ODONA/LTC
NURSING ASSISTANT SCHOLARSHIP
APPLICATION

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

Name: _______________________________________Social Security # _________________

Home Address: ___________________________________ City _______________________

County ___________________________ Zip ___________ Phone # (____)______________

Employer ____

Address ____ City ______________________

Work Phone (____) ______________________ Number of years employed ____________

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. ____

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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 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 and enrollment verification to: ODONA/LTC
433 W Johnstown Road ~ Gahanna, OH 43230
NOTE: The complete application packet must be <u>**received**</u> **by March 1st.**

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
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:____
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How long has the applicant been employed at the facility? ________________

Briefly, describe why this applicant would be a worthy recipient of this scholarship:
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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
2nd Reference 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: ____

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

Briefly, describe why this applicant would be a worthy recipient of this scholarship:

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Signature____**Date**__________________________

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