



Deadline: Applications are due by May 17, 2014
Award recipients will be announced on June 7, 2014
Award will be presented in August of 2014

Step 1: DETERMINE IF YOU ARE ELIGIBLE

Eligible applicants are minorities who:

- ~ Demonstrate financial need
- ~ Are enrolled in, or have been accepted to an accredited Nursing Program in Arizona **FULL TIME STATUS**
- ~ Reside in the state of Arizona
- ~ Have a GPA of 3.0 or above (unofficial transcripts are acceptable)

STEP 2: COMPLETE THE APPLICATION

It is very important that you first save the document to your computer or a USB/thumb drive if you are working on a public computer. Otherwise, you risk losing any information you have entered and will need to begin again. Once you have completed the application, select "Save As" from the "File" menu and change the file name. Move through the application by tabbing to the next field.

STEP 3: OBTAIN REFERENCES

You will need two different people (NOT related to you) to fill out the reference form. Please email this form to your references and request that they email it back to you when complete.

STEP 4: EMAIL YOUR APPLICATION

Completed applications must be submitted to the appropriate address. Please note that incomplete applications will not be considered. Eligible applications include a complete application form, two reference forms, and unofficial transcripts.

Submit your application to kdartez@familytreehealthcare.com



PART I—PERSONAL DATA

Name (last, first, middle initial)

Address (number and street address)

City/Province

State

Postal/Zip Code

Telephone (area code first)

E-mail Address

Date of Birth

Marital Status

of Dependents
Applicant Supports
(NOT including self)

Dependent's Relationship

Age of Dependents (if children)

ACTIVITIES

List participation during the past two years in community and school activities. Include the dates involved, hours per month, leadership positions, and responsibilities. Attach additional page, if needed.

RECOGNITION

List community, school, and volunteer awards and honors received with dates. Attach additional page, if needed.



(Last Name)

PART II—OBTAINING YOUR CAREER GOALS

A. Please list the school you are currently attending, or to which you have been accepted, and your proposed program of study (example: Grand Canyon University, four-year Bachelor of Science degree program in nursing).

B. Please tell us when will you complete your program of study (expected graduation date)

C. Number of credit hours you are currently taking? _____

SIGNATURE OF PROFESSOR OR ACADEMIC ADVISOR:

Name (Printed)

Title/Department

Email Address

Telephone Number



_____ (Last Name)

PART III—PERSONAL STATEMENT

The Lillie Rose Scholarship is awarded to minority nursing students who desire to further their education, and have a heart to serve their communities through patient care, education, and community involvement. Please tell us in 2-3 pages how these statements apply to you, why you choose a career in Nursing, and why you would make a deserving Lillie Rose Award recipient. You may include any other information you feel will be relevant to awarding the scholarship.



_____ (Last Name)

PART IV—FINANCIAL NEED

The Lillie Rose Scholarships are given based in part on financial need. Your total income will be compared to your total annual expenses. Please be as exact as you can.

A. Total annual household income from all sources (include your income from employment, savings, child support, alimony, Social Security benefits, government assistance, and school loans or scholarships. Also include all income received by any other household members).

B. Please list your annual educational expenses **only**—do not include those of your children or other family members.

Tuition/School Fees _____ Books _____

Other (please describe) _____

C. Please list your family's annual living expenses:

Housing \$ _____ per year Utilities \$ _____ per year

Food \$ _____ per year Medical \$ _____ per year

Childcare \$ _____ per year Transportation \$ _____ per year

Other (please list additional expenses and assign a dollar value to each in the space below)

Expense: _____ \$ _____ per year

Expense _____ \$ _____ per year

Expense _____ \$ _____ per year

Expense _____ \$ _____ per year

Total expenses per year: \$ _____

PART V—REFERENCES

You will need two different people (NOT related to you) to fill out the reference form ("ReferenceForm.pdf"). Please email this form to your references and request that they email the forms back to you when completed.



_____ (Last Name)

PART VI—AGREEMENT

- I certify that all information provided in this application is complete and accurate to the best of my knowledge. I will notify Family Tree Healthcare of any changes.
- I understand that my application becomes the property of Family Tree Healthcare. The application will be considered confidential, unless the applicant grants Family Tree Healthcare written permission to release personal information for the purpose of publicizing the Lillie Rose Scholarship program. By typing your name below you adhere to the above requirements.

Typed Signature of Applicant

Date _____

Submit your application to kdartez@familytreehealthcare.com

