



FLORIDA DEPARTMENT OF  
**EDUCATION**  
fldoe.org

**NURSING STUDENT SCHOLARSHIP APPLICATION**

**NOTICE:** Any person who knowingly makes a false statement or misrepresentation on this form is subject to penalties which may include fines, imprisonment or both, under section 837.06, Florida Statutes.

**Personal Information:**

Applicant Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Academic Information:**

Name of School/Nursing Program: \_\_\_\_\_ Intended Major: \_\_\_\_\_

Semester for which application is being made (Term and Year): \_\_\_\_\_

Credit Hours Earned to Date: \_\_\_\_\_ GPA: \_\_\_\_\_

Credit Hours to be taken during semester for which scholarship is awarded: \_\_\_\_\_

I certify that the statements herein are true to the best of my knowledge. My signature below authorizes (name of college) \_\_\_\_\_ to release my academic records and transcripts to the Florida Department of Education, Office of Student Financial Assistance (OSFA).

Student Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_