



INTERNATIONAL ASSOCIATION OF SICKLE CELL NURSES AND PHYSICIAN ASSISTANTS, INC.

SCHOLARSHIP PROGRAM

APPLICATION

The International Association of Sickle Cell Nurses and Physician Assistants, Inc. has established a college scholarship program to assist patients with Sickle Cell Disease who will be attending an institution of higher learning. The Association's Scholarship Committee has determined that selection of recipients will be based upon academic performance, financial need and additional criteria including character, school and community activities and proficiency in written expression. The diversified academic interests and needs of applicants will also be considered in awarding the scholarships.

Applicants for IASCNAPA's \$500 Scholarships must have a sickle hemoglobinopathy and be enrolled in, or have been accepted by a recognized and accredited post secondary school, including college, university, trade school, or other institution of higher learning. Curriculum choice, age, gender, race, ethnic background, religion and political affiliation will not be used in evaluating applications.

An active IASCNAPA member must sponsor all applicants.

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED.

PLEASE PRINT OR TYPE ALL INFORMATION ON THIS APPLICATION.

Mail to:

Deborah Boger, RN
IASCNAPA Scholarship Committee
Children's Medical Center of Dallas
Pediatric Sickle Cell Disease Program
1935 Motor Street, A03.360
Dallas, TX 75235
Deborah.Boger@childrens.com

IASCNAPA SCHOLARSHIP APPLICATION PAGE 1 OF 9

Application for academic year: [_____] to [_____] Today's Date: ____/____/____

Name: _____

Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____

Address: _____

Telephone Number: (_____) _____

Name of active IASCNAPA Member: **(Required)** _____

Complete name and address of school and office where scholarship award is to be sent:

Date accepted: ____/____/____ ***Please attach a copy of your letter of acceptance.**

Career objective: _____

List high school and other schools you have attended. Include name, address, dates of attendance, graduation date, and degree or certificate earned. If more space is needed, please write on the back.

School Name	Address	Dates of Attendance	Degree Earned

In order to be considered for a \$500 IASCNAPA award, the scholarship committee must receive your application along with laboratory results confirming presence of a sickle hemoglobinopathy, recommendations, and transcripts.

One recommendation form **must** be given to an active member of IASCNAPA. It is suggested that the other form be given to a principal, teacher, or counselor who knows you well, your employer or supervisor, or someone in the community who knows you well.

List the names, addresses, email addresses and telephone numbers of the two persons you ask to complete recommendation forms:

1.

2.

GENERAL INFORMATION ABOUT APPLICANT

Applicant's Name: _____

List other grants and scholarships (not loans) for which you have applied, the amount of the grants or scholarships, and whether or not you have been officially notified of an award:

Name of grant	Amount/yr.	Approved	Denied	Don't know
1. _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List all school related expenses for the upcoming academic year:

Tuition and fees: \$ _____

Books and supplies \$ _____

Room: \$ _____

Board: \$ _____

Commuting Expenses: \$ _____

Other: (please specify) \$ _____

Total: \$ _____

List activities, leadership positions and significant responsibilities in school, community, home, church. Applicants who are employed may use this section to provide additional pertinent information.

List honors (scholastic, citizenship, artistic, etc.), awards, and other forms of recognition received:

Have you received an IASCNAPA award previously? No Yes → what year: _____

List hobbies and special interests:

Have you been employed during the school year? No Yes → number of hours/week: _____

Type of job: _____

Have you worked summers? No Yes → Full or part-time? Full-time Part-time

Type of work: _____

Are you working now? No Yes → Full or part-time? Full-time Part-time

Type of work: _____

Recommendation From Active Member of IASCNAPA

Applicant's Name: _____

The above named student is applying for a scholarship from the International Association of Sickle Cell Nurses and Physician Assistants, Inc. (IASCNAPA). These scholarships are available to all individuals with any sickle hemoglobinopathy. Recipients will be selected by the IASCNAPA scholarship committee. Each member of the committee will carefully review all applications.

Scholarship awards will be based upon academic performance and potential, and financial need. Personal motivation, character, the ability to express himself or herself in writing, and involvement in school and community activities will also be considered in the selection process.

Your assistance in evaluating this applicant will be greatly appreciated. Recommendations are a key part of the application process. Your recommendation should be as carefully prepared and descriptive as possible. Please print or type information, using front and back of this page only or attach a separate sheet.

1. Please confirm sickle hemoglobinopathy by initialing here: _____ and attach laboratory confirmation.

2. How long and in what capacity have you known this applicant?

.....

3. Please comment upon the strengths and weaknesses of this applicant, which you feel the committee should consider:

.....

4. Please comment on applicant's financial need:

.....

5. RECOMMENDATION (check one):

This applicant has my highest recommendation. I recommend this applicant with some reservations.

I recommend this applicant with confidence. I do not recommend this applicant.

Signature: _____ Date: _____

Printed name: _____ Title: _____

Address: _____ Telephone: (____) _____

Please return this form to:
(as soon as possible, but no later than July 1 of the application year.)

Deborah Boger, RN
IASCNAPA Scholarship Committee
Children's Medical Center of Dallas
Pediatric Sickle Cell Disease Program 1935 Motor Street, A03.360
Dallas, TX 75235

RECOMMENDATION

Applicant's Name: _____

The above named student is applying for a scholarship from the International Association of Sickle Cell Nurses and Physician Assistants, Inc. (IASCNAPA). These scholarships are available to all individuals with any sickle hemoglobinopathy. Recipients will be selected by the IASCNAPA scholarship committee. Each member of the committee will carefully review all applications.

Scholarship awards will be based upon academic performance and potential, and financial need. Personal motivation, character, the ability to express himself or herself in writing, and involvement in school and community activities will also be considered in the selection process.

Your assistance in evaluating this applicant will be greatly appreciated. Recommendations are a key part of the application process. Your recommendations should be as carefully prepared and descriptive as possible. Please print or type information, using both sides of this page or attaching a separate sheet.

1. How long and in what capacity have you known this applicant?

2. Please comment upon the strengths and weaknesses of this applicant, which you feel the committee should consider.

3. RECOMMENDATION (check one):

- This applicant has my highest recommendation. I recommend this applicant with some reservations.
 I recommend this applicant with confidence. I do not recommend this applicant.

Signature: _____ Date: _____

Printed name: _____ Title: _____

Address: _____ Telephone: (____) _____

Please return this form to:
*(as soon as possible, but
no later than July 1 of the application year)*

Deborah Boger, RN
IASCNAPA Scholarship Committee
Children's Medical Center of Dallas
Pediatric Sickle Cell Disease Program 1935 Motor Street, A03.360
Dallas, TX 75235



**INTERNATIONAL ASSOCIATION OF SICKLE CELL
NURSES AND PHYSICIAN ASSISTANTS, INC.**

**SCHOLARSHIP PROGRAM
TRANSCRIPT REQUEST**

Applicant's Name: _____

TO WHOM IT MAY CONCERN:

I am applying for a scholarship from The International Association of Sickle Cell Nurses and Physician Assistants, Inc. I request that the following information be released to the address ee below:

1. A copy of my complete academic record:
 - a) A transcript of work completed, and
 - b) A listing of courses in which I am currently enrolled, if applicable.
2. Grade point average: _____ Class rank: _____ out of _____ students.
3. A copy of my Scholastic Aptitude Test scores and other pertinent test scores:

Please check here if no scores available:

Please return as soon as possible, but **no later than July 1 of the application year.**

Awards will be made 3 months later in October. Send applications to:

Deborah Boger, R.N.
IASCNAPA Scholarship Committee
Children's Medical Center of Dallas
Pediatric Sickle Cell Disease Program
1935 Motor Street, A03.360
Dallas, TX 75235
Deborah.Boger@childrens.com

Date: _____

**SCHOLARSHIP APPLICATION
CHECK LIST**

- | | | |
|-------------------------------------|---------------|--------------------------|
| Application Form | Page 1 | <input type="checkbox"/> |
| Parent/guardian information | Page 2 | <input type="checkbox"/> |
| General Information | Pages 3 and 4 | <input type="checkbox"/> |
| Personal Statement | Page 5 | <input type="checkbox"/> |
| Recommendations:
IASCNAPA member | Page 6 | <input type="checkbox"/> |
| Other | Page 7 | <input type="checkbox"/> |
| Transcript request | Page 8 | <input type="checkbox"/> |

ATTACHMENTS

- | | |
|---|--------------------------|
| Copy of letter of acceptance | <input type="checkbox"/> |
| Transcripts | <input type="checkbox"/> |
| Copy of SAT/ACT score or
Grades from last college semester | <input type="checkbox"/> |

Signature of Applicant: _____ **Date:** _____

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED