THE DIANA JOYCE DOROS ENDOWED SCHOLARSHIP

McKendree University - Fall Scholarship Application

Description:
This endowed scholarship fund makes available $5,000 awards divided over the duration of the program for students pursuing a Bachelor of Science Degree in Nursing (BSN) or a Master of Science in Nursing (MSN) in Population Health. The scholarship honors the memory of the late Diana Joyce Doros. The Doros family gifted the $750,000 endowed scholarship is in memory of Diana, remembering the nurses who helped and cared for Diana, who had cancer before she passed away in 1994.

Completed applications must be submitted by July 15 to: Carol Fairlie, McKendree University, 701 College Road, Lebanon, IL 62254, cjfairlie@mckendree.edu or fax to 618-537-6530. Questions call: 618-537-6507.

Eligibility and Criteria:

1. Must be admitted or enrolled to the Bachelor of Science in Nursing (BSN) Completion Program or a Master of Science in Nursing in Population Health.
2. BSN: minimum 2.5 GPA in undergraduate program to apply. MSN: minimum 3.0 GPA in undergraduate program (cumulative) to apply.
3. Not be employed where tuition reimbursement is offered.
4. Must submit a two- to three-page personal and professional reflection demonstrating the student's motivation for higher education, aspirations, projected impact the scholarship will make on the student's nursing practice and anticipated timeline for completing the program.
   Areas of consideration include:
   a. Linking of personal nursing practice with the values of nursing.
   b. Dedication to strengthening the nursing workforce.
   c. Value of lifelong learning.
   d. Contribution to the community's health and well-being.
5. Must submit one-page statement showing demonstrated financial need (self-proclaimed).
6. Maintain minimum of 2.5 GPA for the BSN and 3.0 GPA for the MSN throughout the McKendree program.

Payment Schedule

The scholarship will be issued in August prior to the fall semester at McKendree University and disbursed over the duration of the program.

I understand the terms of this scholarship and agree to them. I also understand that if during the time enrolled that I receive employer reimbursement the scholarship will be ceased.

Name_____ **Date**_____

Social Security Number_____ **Phone** _____

Address_____

City_____ **State**_____ **Zip**_____

Program pursuing (circle program)**: BSN or MSN in Population Health**

Signature_____**Date**_____

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