



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.

Applicants for IASCNAPA's \$500 Scholarships must have a form of sickle cell disease 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 or a sickle cell disease medical provider must sponsor all applicants.

Applications are accepted from March 1 through July 1 of each year.

Awards will be given in August of each year.

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED.

PLEASE PRINT OR TYPE ALL INFORMATION ON THIS APPLICATION.

Mail to:

Deborah Boger, RN, CPNP
IASCNAPA Scholarship Committee
Children's Medical Center of Dallas
Pediatric Sickle Cell Disease Program
1935 Medical District Drive, A3131.03
Dallas, TX 75235
dboger@childrens.com

IASCNAPA SCHOLARSHIP APPLICATION PAGE 1 OF 7

Application for academic year: [_____] to [_____] Today's Date: ____/____/____
 Name: _____
 Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____
 Address: _____
 Telephone Number: (_____) _____

Name of active IASCNAPA Member or Sickle Cell Disease Medical Provider: **(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,

School Name	Address

One recommendation form **must** be given to an active member of IASCNAPA or your sickle cell medical provider. 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:

First Recommendation	Second Recommendation

GENERAL INFORMATION ABOUT APPLICANT

Applicant's Name: _____

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 or Sickle Cell Disease Medical Provider

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. 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. 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:
(BY July 1 of the application year.)

Deborah Boger, RN, CPNP
Children's Medical Center of Dallas
Pediatric Sickle Cell Disease Program
1935 Medical Center Blvd, A3131.03
Dallas, TX 75235

RECOMMENDATION

Applicant's Name: _____

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**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 addressee 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: []

Must be returned by **July 1 of the application year.**

Awards will be made in August of that year. Send application information to:

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

**SCHOLARSHIP APPLICATION
CHECK LIST**

Application Form	Page 1	<input type="checkbox"/>
General Information	Page 2	<input type="checkbox"/>
Personal Statement	Page 3	<input type="checkbox"/>
Recommendations:		
IASCNAPA member	Page 4	<input type="checkbox"/>
Other	Page 5	<input type="checkbox"/>
Transcript request	Page 6	<input type="checkbox"/>

ATTACHMENTS

Copy of letter of acceptance

Transcripts

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

***INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED**