STIPEND APPLICATION

NURSING WORKFORCE
DIVERSITY

NWDP
NURSING WORKFORCE DIVERSITY PROGRAM

CONTACT INFORMATION

BETHEL

NAME:		STUDENT ID:	
DAY PHONE:	MSG PHONE:	Spring ____ Summer ____ Fall ____	
E-MAIL:		DATE OF BIRTH:	
MAILING ADDRESS:	CITY:	STATE:	ZIP:
ETHNICITY:		Hispanic or Latino	
NURSING MAJOR:	BS / BACCALAUREATE ☐	AAS / ASSOCIATE of APPLIED SCIENCE ☐	

OTHER INFORMATION

A. Please answer one of the following questions:

1. What is your cultural background and what motivated you to pursue the profession of nursing?

2. How has the Nursing Workforce Diversity Program influenced your academic/nursing experience?

SIGNATURE

I give permission for NWDP staff to discuss my progress with course instructors.

I acknowledge that completion of this application does not entitle me to a stipend payment. I understand that I must complete the NWDP Stipend Program requirements before I will be eligible for stipend funds.

Signed _____ Date _____