



St. John Ambulance

NURSING STUDIES BURSARY APPLICATION FORM

ALL CATEGORIES — INCLUDING CONTINUING AID

To apply for a St. John Ambulance Nursing Bursary, you must:

- 1) Fill in all sections of this application that are applicable to you. Please print clearly or type.
- 2) Forward your completed application together with all supporting documentation by the MARCH 15th deadline to the following location:

Bursary Award Program
St. John Council for Ontario
c/o Mrs. Gail Opaleychuk
46 Wellesley Street East
Toronto, Ontario M4Y 1G4

If faxing or e-mailing your application, **ORIGINAL DOCUMENTS MUST BE RECEIVED** at your Provincial Council / Special Centre Office within one week of the deadline. **DO NOT FORGET** to include two written references with your submission. Incomplete applications **WILL NOT BE FORWARDED TO NATIONAL OFFICE FOR CONSIDERATION**.

There are three steps to the application review process:

- 1) Your file will be reviewed for completeness and summarized by your Provincial/Territorial Council or Special Centre prior to forwarding to the National Bursary Committee.
- 2) All completed applications will be reviewed by the Committee to determine eligibility based on the criteria established and categorized by academic achievement, financial need, commitment to St. John Ambulance, etc.
- 3) You will be notified of your application status. If successful, you will be asked to forward your confirmation of acceptance in the chosen program of study, your final transcripts and your Social Insurance Number prior to receiving a Bursary Award. Original documents will not be returned.

PRIVACY STATEMENT

St. John Ambulance is committed to your privacy. The personal information you have provided us within this application form will be used to determine your eligibility for the nursing studies bursary. Following the notification to the selected candidates of their application status, the information of those individuals selected will be retained at St. John Ambulance National Office for a period of 10 years. The information of those individuals who were not eligible will be destroyed within two years following the issuance of notification. Should you wish to have access to the information about yourself, to review it and/or ask for corrections or add annotations to it, please contact the Awards Program Coordinator at St. John Ambulance National Office, 400-1900 City Park Dr., Ottawa, Ontario K1J 1A3. For further information about St. John Ambulance's Privacy Policy, please contact our Privacy Officer at the address above or by email at privacyofficer@sja.ca.

A. GENERAL INFORMATION

Please indicate for which program you wish to obtain financial assistance.

- Diploma
- Baccalaureate (Degree)
- Graduate (Masters, Doctoral)
- Post Diploma/Baccalaureate Specialization
- Continuing Aid in any of the above (*indicate which program*) _____

NAME:			
	FIRST	MIDDLE	LAST
PERMANENT ADDRESS:	NUMBER AND STREET / RURAL ROUTE / PO BOX #		
	CITY	PROVINCE	POSTAL CODE
PHONE NUMBERS :			
	HOME		WORK

B. EDUCATIONAL BACKGROUND

List educational institutions attended giving most recent first. (ATTACH SECOND SHEET IS NECESSARY.)

INSTITUTION & LOCATION	ATTENDANCE DATES	DIPLOMA / DEGREE CERTIFICATE RECEIVED (IF APPLICABLE)	MAJOR INTEREST OR SPECIALIZATION

- Attach official transcripts of grades from your most recent secondary school program and/or most recent educational program, or where applicable, your nursing program.
- Include a photocopy of your current provincial/territorial membership certificate, license or certificate of competence (where applicable).

C. WORK EXPERIENCE

List current or last position held first. (ATTACH SECOND SHEET IS NECESSARY.)

POSITION / TITLE	EMPLOYER & LOCATION	DATES

D. ST. JOHN AMBULANCE ACTIVITIES

Affiliation with and service commitment to St. John Ambulance are requirements for the granting of bursaries in all instances.

1. Describe your affiliation, past and present, with St. John Ambulance (capacity, years served, number and type of courses taught).

2. Upon completion of your nursing program, describe how you will continue to assist St. John Ambulance, in what capacity and where.

E. OTHER PROFESSIONAL & COMMUNITY ACTIVITIES

1. List all professional organizations in which you are or have been recently active and any offices / positions held.

2. List all civic and community organizations in which you are or have been recently active.

3. List all honours and awards received.

F. PROPOSED PROGRAM OF STUDY

This section must be completed *even if you do not know* your acceptance status.

SPECIFY NURSING PROGRAM:		
<input type="checkbox"/> GRADUATE	<input type="checkbox"/> MASTERS	<input type="checkbox"/> DOCTORAL
<input type="checkbox"/> BACCALAUREATE DEGREE	<input type="checkbox"/> GENERIC / COLLABORATIVE PROGRAM	<input type="checkbox"/> POST R.N. BACCALAUREATE
<input type="checkbox"/> DIPLOMA	<input type="checkbox"/> POST DIPLOMA / BACCALAUREATE SPECIALIZATION (SPECIFY)	
INSTITUTION & LOCATION:		
STUDIES WILL BE:	<input type="checkbox"/> FULL-TIME	COMPLETE SECTION F.1
	<input type="checkbox"/> PART-TIME	COMPLETE SECTION F.2

F.1 Full-Time Studies Only

LENGTH OF TOTAL PROGRAM OF STUDY:			
DATES OF PROPOSED PROGRAM OF STUDY FOR WHICH THIS ASSISTANCE IS REQUESTED:			
FROM:		To:	
WHICH YEAR OF STUDY ARE YOU ENTERING?			
<input type="checkbox"/> First	<input type="checkbox"/> Second	<input type="checkbox"/> Third	<input type="checkbox"/> Fourth
WHAT IS YOUR ACCEPTANCE STATUS?		<input type="checkbox"/> CONFIRMED (PROOF REQUIRED)	
		<input type="checkbox"/> TENTATIVE	

F.2 Part-Time Studies Only

F.2.1 Diploma / Baccalaureate / Graduate Program

NAME OF THE PROGRAM :			
NUMBER OF COURSES TO BE TAKEN IN THE COMING YEAR :		NUMBER OF COURSES TO BE TAKEN AT ONE TIME:	
COST PER COURSE:	\$	NUMBER OF COURSES REQUIRED TO COMPLETE THE PROGRAM :	
MODE OF STUDY (E.G. ON-LINE, CORRESPONDENCE, LONG-DISTANCE, CLASSROOM, ETC.)		DURATION OF EACH COURSE (E.G. SEMESTER, ACADEMIC YEAR, ETC.):	
WHAT IS YOUR ACCEPTANCE STATUS ?	<input type="checkbox"/> CONFIRMED (PROOF REQUIRED) <input type="checkbox"/> TENTATIVE		

F.2.2. Nursing Specialty Program

NAME OF THE SPECIALITY:			
NUMBER OF COURSES TO BE TAKEN IN THE COMING YEAR :		NUMBER OF COURSES TO BE TAKEN AT ONE TIME:	
COST PER COURSE:	\$	NUMBER OF COURSES REQUIRED TO COMPLETE THE PROGRAM :	
MODE OF STUDY (E.G. ON-LINE, CORRESPONDENCE, LONG-DISTANCE, CLASSROOM, ETC.)		DURATION OF EACH COURSE (E.G. SEMESTER, ACADEMIC YEAR, ETC.):	
CERTIFICATE OR DIPLOMA EXPECTED ON COMPLETION			
WHAT IS YOUR ACCEPTANCE STATUS ?	<input type="checkbox"/> CONFIRMED (PROOF REQUIRED) <input type="checkbox"/> TENTATIVE		

G. FINANCES

STATE ANTICIPATED EXPENSES FOR UPCOMING YEAR:	
A) TUITION FEES	\$
B) BOOKS AND SUPPLIES	\$
C) TRAVEL	\$
D) ROOM AND BOARD	\$
E) OTHER (SPECIFY)	\$
TOTAL:	\$

STATE OTHER FINANCIAL ASSISTANCE REQUESTED AND/OR RECEIVED AND AMOUNT(S).	
	\$
	\$
	\$

DO YOU HAVE OTHER MEANS OF FINANCIAL SUPPORT? STATE SOURCE AND AMOUNT (S).	
	\$
	\$
	#

DEGREE OF DEPENDENCY ON BURSARY ASSISTANCE (HIGH, MEDIUM, LOW & STATE WHY).

STATE EXTENT OF FINANCIAL RESPONSIBILITY FOR DEPENDENTS (IF ANY).

HOW WERE YOU MADE AWARE OF THE ST. JOHN AMBULANCE BURSARY AWARDS?

HAVE YOU PREVIOUSLY RECEIVED A ST. JOHN AMBULANCE BURSARY AWARD FROM EITHER THE NATIONAL BURSARY COMMITTEE OR FROM A PROVINCIAL COUNCIL? IF SO, PLEASE STATE THE SOURCE OF THE AWARD, THE YEAR AND THE AMOUNT RECEIVED.

SOURCE	YEAR RECEIVED	AMOUNT
		\$
		\$
		\$

WHAT ARE YOUR CAREER GOALS?

H. REFERENCES (New Applicants Only)

A minimum of two written references are required and are an integral part of your application submission. One must be from an individual who has known you for the past five years and who can evaluate your job performance, educational aptitude and leadership potential. The other **must** be from the St. John Ambulance Community Service **Officer** or Director of Training. References must be provided on the approved Reference Form and must be signed and dated.

Letters of reference are mandatory for your file to be complete. These letters must form part of the application submission to National Headquarters to be considered complete. The Bursary Committee will not review incomplete files.

I, _____ understand that:
 (PLEASE PRINT NAME.)

- a) if I am unable to complete the program as funded, the St. John Ambulance Bursary Committee reserves the right to require repayment of my award, in whole or in part.
- b) in the event that false information is provided, bursary acceptance will be invalidated.

 (Date)

 (Signature)