SOUTH DAKOTA BOARD OF NURSING
SOUTH DAKOTA DEPARTMENT OF HEALTH
4305 South Louise Avenue Suite 201
Sioux Falls SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768
www.state.sd.us/doh/nursing

NURSING EDUCATION SCHOLARSHIP APPLICATION

RN: *Submit to the Board of Nursing by June 1st of the year in which the application is to be considered.*
LPN: *Submit to the Board of Nursing by October 1st of the year in which the application is to be considered.*

APPLICANT: _____
First MI Last

ADDRESS: _____
Street City State Zip

TELEPHONE: _____ EMAIL: _____

I am a nursing student at (list your school): _____

Do you have a current SD Nursing License: YES / NO
If yes, list License Number: _____

AFFIDAVIT AND RELEASE OF INFORMATION AUTHORIZATION

- I declare that I am the person authorized in this application and all statements are true and correct.
- **I declare that I am a resident of South Dakota and have been for at least one year.**
- I authorized the above named nursing education program to release the information requested below the South Dakota Board of Nursing for purposed of determine eligibility for the nursing education scholarship.

SIGNATURE OF APPLICANT:_____ DATE:_____

NURSING PROGRAM DIRECTOR: Please complete this section and return to the applicant.

Expected Graduation Date: _____ GPA (Cumulative):_____ Degree Sought:_____

_____ _____
SIGNATURE OF NURSING PROGRAM DIRECTOR DATE

FINANCIAL AID OFFICER: Please complete this section and return to applicant.

Estimated Tuition and Fees for the academic year: _____

Total Educational Grants provided to applicant: _____

Total Scholarships provided to applicant: _____

_____ _____
SIGNATURE OF FINANCIAL AID OFFICER DATE