OHS/LNR-900 (01/00)

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF HEALTH PROFESSIONS
P.O. BOX 30670
Lansing, Michigan 48909

Notification of Intent to Award Scholarship

Authority: P.A. 369 of 1978, as amended
Completion of this form is required for scholarship award.

Name of Student (Last Name, First Name, Middle Name)		
Street Address		
City	State	ZIP Code
Michigan RN License Number (if applicable)	Program (Check One) ☐ LPN ☐ ADN ☐ BSN	MSN Specialty Program (Check One) ☐ Nurse Educator-degree ☐ Nurse Practitioner ☐ Nurse Midwife ☐ Nurse Anesthetist
Nursing Program Director		
Name of Educational Institution		Telephone Number

Statement of assurance that applicant is not in receipt of a full scholarship
Michigan medically under served area, medically underserved population or health professional shortage area in which applicant agrees to serve: (RN is whole state)

Authorized Signature for Educational Institution ____________________ Date ____________________