**THE NURSES MEMORIAL FOUNDATION OF SOUTH AUSTRALIA LIMITED**

**THE DR. ROGER WURM SCHOLARSHIP APPLICATION FORM**

(Please refer to attachment for eligibility)

**Applicant**: (title) .………..…... (Surname) ………...… (Given names)……………………………………..………………………..

**CONTACT DETAILS:** **(Postal address, telephone, email)** …………………………………………………………………………… ………………………………………………………………………………………………………………………………………………………….………

**COUNTRY OF BIRTH** …………………………………….AUSTRALIAN CITIZEN .. YES/NO. IF YES, PROVIDE EVIDENCE

**LANGUAGES SPOKEN**…………………………………………………………………………………………………………………………

**QUALIFICATIONS** (If a Graduate – Diplomas, Degrees, Practicing Certificates) – copies to be attached

**PLACE OF EMPLOYMENT**…………………………………………………………………………………………………………………….…..

**NAME, ADDRESS, CONTACT DETAILS OF TWO REFEREES**

1. ………..…………………………………………………………………………………………………………………………………………
2. ……………………………………………………………………………………………………………………………………………………

**COSTS ANTICIPATED: Itemise in an attachment. TOTAL AMOUNT REQUESTED: $.................................**

**PLEASE ATTACH:**

* A synopsis of reasons for requesting a scholarship – no more than one page
* Copy of Registration, endorsement, enrolment as a student / practitioner
* Evidence of enrolment or registration n an educational program details
* Study plan, conference program, academic transcripts
* Copy of receipts (if relevant)
* Copy of recent photograph – passport size is satisfactory
* Any other relevant information - specify

**THE ASSESSING COMMITTEE -**

may contact you to clarify and part(s) of your application and will automatically reject the application of any data requested is not provided.

**COPIES:**

Please provide original and 2 complete copies of your application.

**Reporting:**

Successful applicants are required to submit a written report at the completion of their Scholarship and before final payment is made.

ACKNOWLEDGEMENT:

Any publication relevant to this Scholarship must acknowledge the Nurses’ Memorial Foundation of South Australia Limited.

**DECLARATION:**

**“I DECLARE THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT.**

**I ACCEPT THAT MY APPLICATION MAY BE UNSUCCESSFUL AND RESPECT THE DECISION OF THE FOUNDATION AS BEING FINAL”.**

**SIGNED…………………………………………… DATED…………………………………………**

**REMINDER: CLOSING DATE: APRIL 30TH annually;**

**PLEASE FORWARD YOUR APPLICATION TO:**

**THE SECRETARY,**

**NURSES’ MEMORIAL FOUNDATION OF SOUTH AUSTRALIA LIMITED**

**18 DEQUETTEVILLE TERRACE,**

**KENT TOWN, SA, 5067**