



**MEDICATION AIDE SCHOLARSHIP APPLICATION FOR LONG TERM CARE**

To assist qualified persons who wish to become a medication aide in the long term care profession, the Nebraska Health Care Foundation, Inc. will award one (1) scholarship per quarter for a total of four (4) scholarships per year for persons wishing to attend the Nebraska Health Care Learning Center Medication Aide Training. Scholarships will be awarded January 1, April 1, July 1, and October 1, and must be used within six months of being awarded. Persons eligible to apply for a scholarship must:

1. Be eligible to enroll in the Nebraska Health Care Learning Center Medication Aide Training.
2. Be presently employed in a Nebraska Health Care Association/Nebraska Assisted Living Association member facility.
3. Must be able to attend Nebraska Health Care Learning Center Medication Aide Training within six months of receiving the scholarship.
4. Pledge that, upon successful completion of the course, they practice their skills in the long term care setting for at least one year.

**Complete the following application form and give the enclosed recommendation form to one reference:** the administrator/director of nursing/department head of the NHCA/NALA member facility where you are presently employed. **The completed reference must be placed in a sealed envelope and submitted to the Nebraska Health Care Foundation along with the completed application form.** **INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED.**

**IMPORTANT MEDICATION AIDE SCHOLARSHIP DATES**

Due Date	Awarded	Use By
March 1	April 1	October 1
June 1	July 1	January 1
September 1	October 1	April 1
December 1	January 1	July 1

**Scholarship winners will be notified by mail and must use the scholarship within six months of being awarded.**

*PLEASE PRINT OR TYPE*

Name \_\_\_\_\_

Permanent Address/City/Zip \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Facility Where Employed \_\_\_\_\_

Address/City/Zip \_\_\_\_\_

Supervisor \_\_\_\_\_

Length of employment in a long term care facility: \_\_\_\_\_

**(Form continued on reverse)**

Have you had any other special training or instruction related to long term care? If so, please explain:

---

---

Have you ever worked as a volunteer in long term care? If so, please explain: \_\_\_\_\_

---

---

---

Please describe your interest in long term care including how you became interested in the profession and related experiences. \_\_\_\_\_

---

---

---

---

Please describe your future professional plans in the health care field and your commitment to the long term care area. \_\_\_\_\_

---

---

---

---

If you are awarded a scholarship, do you pledge to practice your skills in a long term care facility setting for at least one year after completing your course of instruction?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

**RETURN THIS APPLICATION AND THE RECOMMENDATION FORM BY THE APPROPRIATE DUE DATE TO:**

Nebraska Health Care Foundation  
3900 NW 12th St Ste 100  
Lincoln, NE 68521-3037

\_\_\_\_\_  
**(Signature)**

\_\_\_\_\_  
**(Date)**



**RECOMMENDATION FORM**

**SCHOLARSHIP FOR PERSONS INTERESTED IN MEDICATION AIDE TRAINING  
WITH A COMMITMENT TO LONG TERM CARE**

Nebraska Health Care Foundation, Inc. will award one scholarship, per quarter, for a total of four scholarships per year, to persons qualified to enroll in the Nebraska Health Care Learning Center Medication Aide Training. Recipients must pledge that, upon successful completion of the course, they will practice skills in the long term care setting for a minimum of one year. Scholarship winners will be notified by mail and will have six months to use the scholarship after it has been awarded. Scholarship applications will be kept active for six months.

**Please place completed form in a sealed envelope and return it to the applicant.**

**IMPORTANT MEDICATION AIDE SCHOLARSHIP DATES**

Due Date	Awarded	Use By
March 1	April 1	October 1
June 1	July 1	January 1
September 1	October 1	April 1
December 1	January 1	July 1

**ALL RECOMMENDATIONS WILL BE KEPT CONFIDENTIAL**

*PLEASE PRINT OR TYPE*

Name of applicant \_\_\_\_\_

Name of reference \_\_\_\_\_

Address of reference \_\_\_\_\_

Phone number of reference \_\_\_\_\_ E-mail of reference \_\_\_\_\_

Position of reference \_\_\_\_\_

How long have you known the applicant? \_\_\_\_\_

What is your relationship to the applicant (administrator, DON, etc.)? \_\_\_\_\_

How would you rate the applicant on the following (check each category)?

	LOW	AVERAGE	HIGH	NO OPINION
<b>Maturity</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Sensitivity to Residents' Needs</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Commitment to Long Term Care</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Academic Abilities</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ability to Communicate</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Leadership Skills</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Positive Customer Service Attitude</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please attach a brief statement, **on a blank page or the back of this form**, describing why you believe this applicant would be a worthy recipient of a Nebraska Health Care Foundation, Inc. Scholarship.

\_\_\_\_\_  
**(Signature)**