

The Lake County PEL Legacy Grant Application Form

Last Name: _____ First Name: _____

Address: _____

Telephone: Personal: _____ Work: _____

Personal E-mail: _____

IASN/NASN Membership #: _____

College/University Where BSN Obtained: _____

Date of Graduation: _____

School Nurse Certification Program: _____

Date enrolled in/accepted into the Certification Program: _____

Name of District where will serve/served Internship: _____

Date you anticipate being eligible for PEL-CSN Certification: _____

Current Employer: _____

Employer's Address: _____

Current Job Position: _____

Explain any large financial obligations (college tuition, medical bills, child support, etc):

List your professional activities (committee work, local projects you helped with, IASN Involvement, conferences attended, etc)

*Attach a letter (500 words or less) to the Illinois Association of School Nurses Foundation (IASN - F) regarding your philosophy of school nursing and aspirations / goals for contributing to the professional school nursing in Illinois.

A School Nursing Certification Program faculty member MUST verify your enrollment.

Program Faculty Member Name: _____

Position: _____

Email: _____

Signature: _____ Date: _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND CORRECT.

Applicant's Signature: _____ Date: _____