

Professional Nurse Traineeship Application

College of Nursing
University of South Carolina

Instructions

1. A traineeship is a monetary award from the federal government to support full-time graduate students in nursing who are pursuing an advanced degree.
2. Academic performance and full-time study (9 semester hours for fall and spring) are the primary criteria used in awarding traineeships. **Traineeship support for part-time students is limited to students in their final graduating semester only.**
3. Course enrollment projections must be on file in the College of Nursing for the Fall and Spring semesters for which funds are requested.
4. Current recipients must reapply each year **to be considered** for continued support. Completed applications must be submitted to the Office of Student Services (OSS) by **May 15***. Mailed applications must be received in OSS by **May 15***. They should be mailed to:

Office of Student Services
College of Nursing
University of South Carolina
Columbia, SC 29208

**New students for 2005-2006 accepted after May 15 will have an opportunity to apply during their orientation.*

5. Federal traineeship support is limited to a maximum period of 36 months for each graduate student.
6. Traineeship recipients will be notified of their selection by late summer (August 2007).

Received: _____ Entered: _____
For Administrative use only: GPA _____ FT _____ Award _____



UNIVERSITY OF
SOUTH CAROLINA

USC College of Nursing
Postmark Deadline: May 15, 2007

PROFESSIONAL NURSE TRAINEESHIP APPLICATION

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Personal and Demographic Information

Last Name		First Name		Middle Initial
Social Security Number		E-mail address		
Present Address				
City	County	State	Zip Code (+4)	
Permanent Address				
City	County	State	Zip Code (+4)	
Present phone ()		Permanent phone ()		
Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, do you possess a visa permitting U.S. residency? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Projected Degree and Enrollment Information (effective Fall 2007)

If you will be a **Master of Science in Nursing Student**, indicate emphasis:

Acute Care Clinical Specialist <input type="checkbox"/>	Community / Public Health Clinical Nurse Specialist <input type="checkbox"/>	Psychiatric Mental Health Clinical Specialist <input type="checkbox"/>
Acute Care Nurse Practitioner <input type="checkbox"/>	Family Nurse Practitioner <input type="checkbox"/>	Psychiatric Mental Health Nurse Practitioner/ Specialist <input type="checkbox"/>
Adult Nurse Practitioner <input type="checkbox"/>	Pediatric Nurse Practitioner <input type="checkbox"/>	Women's Health Nurse Practitioner <input type="checkbox"/>

If you will be a **Post-Master Certificate of Graduate Study in Advanced Practice Nursing Student**, indicate emphasis:

Acute Care Nurse Practitioner <input type="checkbox"/>	Family Nurse Practitioner <input type="checkbox"/>	Psychiatric Mental Health Nurse Practitioner / Specialist <input type="checkbox"/>
Adult Nurse Practitioner <input type="checkbox"/>	Pediatric Nurse Practitioner <input type="checkbox"/>	Women's Health Nurse Practitioner <input type="checkbox"/>

Will you be a **Master of Science in Nursing/Master of Public Health Student** (dual degree)? Yes

If you will be a **Doctor of Nursing Practice Student**, indicate level of entry preparation:

Non-BSN prepared BSN prepared MSN prepared

If you will be a **Doctor of Philosophy in Nursing Science Student**, indicate level of entry preparation:

BSN prepared Master's prepared

How many hours have you earned toward your degree? _____

You plan to graduate in:

Fall Spring Summer of 20_____

Provide information below regarding the term(s) for which you are seeking support, the number of hours in which you will be enrolled, and the specific courses you are projected to take. This must coincide with projections on file in your student record.

Fall 2007:	Number of hours enrolled: _____	Projected Courses: _____
Spring 2008:	Number of hours enrolled: _____	Projected Courses: _____

Goals: Briefly share your professional nursing goals and your plans for achieving them.

Financial Aid: Complete statements that apply to you.

I have received a Professional Nurse Traineeship for _____ months (include any traineeships granted by other institutions as well as USC).

I will be receiving aid from sources other than the University of South Carolina and the College of Nursing.

Name of Source: _____ Amount _____

Name of Source: _____ Amount _____

Name of Source: _____ Amount _____

I am receiving educational funds from the Armed Forces or another Federal Source. Yes No

Certification

IMPORTANT: Your signature is required below. Without your signature, your application is not complete.

I authorize the Office of Student Services to release my name, address, telephone number, and place of employment for reporting purposes to the Department of Health and Human Services, Washington, DC for the Professional Nurse Traineeship for three years following graduation.

SIGNATURE OF APPLICANT (IN INK)

DATE OF APPLICATION

The University of South Carolina complies with Title IX and other civil rights law and offers equal opportunity in it employment, admissions and educational activities.

Revised 4/07