COMMUNITY FOUNDATION
Ocala Marion County

ANGELICA G. MUNS NURSING SCHOLARSHIP

Deadline for scholarship application is **Friday, July 30, 2021**

The Community Foundation for Ocala Marion County is pleased to sponsor the Angelica G. Muns Nursing Scholarship. Mrs. Muns, a United States Airforce Lt. Colonel, was a registered nurse who served during World War II. Her love of her service and her profession led to her desire to establish a nursing scholarship to ensure that those wanting to excel in the field of nursing had the opportunity to attend school to become an RN or BSN. Mrs. Muns and her husband were provided excellent healthcare in Marion County and her scholarship is established for those students who plan on staying in Marion County and working at a Marion County acute healthcare facility. In August & January of each year, $2000 will be awarded to scholarship recipients. Recipients must maintain a 3.0 GPA through the duration of nursing school. Please read carefully the requirement for applying for the scholarship.

Application must be postmarked on or before
Friday, July 30, 2021.
Mail to:
Community Foundation for Ocala Marion County
Angelica G. Muns Scholarship
324 SE 24th Street
Ocala, FL 34471
For more information contact:
Lauren Deiorio
President/Executive Director
(352) 622-5020

COMMUNITY FOUNDATION
Ocala Marion County

Scholarship Application

Student Information

Student Name: _____

Address: _____

City/State/Zipp: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

DOB _____ Last 4 digits of S.S # _____

School Enrollment Information

Name of Program: _____

Name of School: _____

Expected Graduation Date: _____

Cumulative G.P.A.: _____

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Scholarship Attachments Required for Application Process for:

1. Those seeking to become RNs who have completed the fundamentals of nursing.

OR

2. RN to BSN

Please attach the following to this application.

1.) Written letters of reference from both of the following:
   a. Nursing Clinical Instructor
      AND
   b. A Personal Reference.

2.) Official or Unofficial Transcripts (official preferred)
   a. Must reflect & maintain a GPA of 3.0 to qualify and remain in the program

3.) Essay
   a. Maximum length 2 typed pages, double spaced in 12 pt. Times New Roman font
   b. Essay Topic - Describe your personal aspirations and career goals. Explain how the Community Foundation Scholarship will impact your ability to reach these goals and in return impact our community.

*No documents submitted by applicant will be returned following the review process.

I certify that the information I have provided on this application is true and accurate; and that any false or misleading information given in my application is grounds for dismissal or termination of scholarship. By signing this application, I agree that I have read and fully understand all information within this application.

Signature of Applicant

Date

COMMUNITY FOUNDATION
Ocala Marion County

Memorandum of Understanding

I,_____understand and agree that I have been awarded a scholarship by the Community Foundation for Ocala/Marion County.

I agree to:

- provide a copy of my grades every semester and maintain a cumulative GPA of 3.0 or higher in all courses. Withdrawal from a term which is part of the program the recipient is in, will disqualify the recipient from this scholarship.
- be either a full-time or part-time student.
- work in a full-time position - post-licensure – providing nursing services at a general acute care hospital in Marion County.
- work 12 months (post-licensure) for the first $2000 in scholarships awarded. For every additional $2000.00 received, I understand that an additional 6 months will be added to my commitment. **(See Attachment A)**
- participate in activities as requested by the Community Foundation for Ocala/Marion County.

Continuation of scholarship is contingent on satisfactory clinical manager or instructor evaluation and maintaining a cumulative GPA of 3.0 or higher each semester. Any deviation from the scholarship requirements may result in necessary appearance before the scholarship committee.

Maximum scholarship payout for ADN program at $2,000 per award is $6,000
Maximum scholarship payout for RN to BSN program at $2,000 per award is $6,000

Scholarship monies will be distributed in August and January of each year in the amount of $2000.00. Distribution will be made directly to the student. Scholarship recipients are responsible for tax reporting as documented via a form 1099 generated at calendar year end.

If I do not, for any reason, fulfill the accompanying employment commitment, I understand that I will be required to repay the total amount of scholarships received on a pro- rated basis. The actual repayment fee due upon termination of employment will be based upon calendar months completed post-graduation and licensure as an RN or BSN. If repayment does not occur, I will be subject to further collection efforts and may include referral to collection agencies and judgments and liens. The calendar term of service will begin on the date of licensure as an RN or BSN. The agreement does not alter, or intend to alter, the at-will employment relationship as provided under Florida Law.

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE STATEMENT

Name (Print):_____Date: _____

Signature: _____

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Ocala Marion County

ESSAY AUTHORIZATION

WE WOULD LIKE TO ASK PERMISSION TO UTILIZE YOUR ESSAY IF WE CHOOSE TO SHARE WITH OTHERS. PLEASE LET US KNOW IF YOU WILL ALLOW US TO USE YOUR ESSAY.

_____ YES
I AUTHORIZE THE COMMUNITY FOUNDATION TO USE MY ESSAY.

_____ NO
I WOULD PREFER NOT TO SHARE MY ESSAY AND
DO NOT AUTHORIZE THE COMMUNITY FOUNDATION TO
USE MY ESSAY.

Name _____ Date _____

Signature _____

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ATTACHMENT A
Employment Verification Form
(to be kept for annual reporting purposes once employed)

Per the work commitment outlined in the *Memorandum of Understanding*, it is the responsibility of the award recipient to verify their employment status annually with the Community Foundation. Please utilize this form to verify your current employment status and return it to the Community Foundation.

Note: Those award recipients who do not comply will be subject to repayment of partial or all of their award funds.

Award Recipient Name: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Recipient Email: _____

Current Employer: _____

Employer Address: _____

_____

Supervisor's Name & Title: _____

Supervisor's Contact Number: _____

I _____, certify that _____, is currently employed at the facility indicated above.

_____ _____

Supervisor's Signature Date