First Bank & Trust | WEALTH MANAGEMENT SERVICES

# WALTER N. GRAHAM AND DOROTHY D. GRAHAM SCHOLARSHIP FUND
# NURSING SCHOLARSHIP PROGRAM

Purpose of the Trust: The Walter N. Graham Nursing Scholarship is established pursuant to the trust agreement of Dorothy D. Graham for the purpose of providing scholarships for **South Dakota residents attending accredited registered nursing programs in South Dakota institutions, public and private.**

Scholarship Committee: A Scholarship Committee consisting of appointees of First Bank & Trust, Sanford Hospital (formerly Sioux Valley Hospital) and the South Dakota Board of Nursing has been established to implement the purpose of the trust, review applications and award scholarships. Decisions regarding recipients, amount, and number of awards will be made at the sole discretion of the Committee.

Eligibility Requirements: Applicants must be enrolled in a South Dakota accredited four (4) year nursing program, must have previously earned **24 nursing credits**, and maintained a 2.5 or better accumulated GPA. **Applicants must be a South Dakota resident**. Financial need may be considered.

Sending Applications: All Completed Applications can be sent as such from Student or Financial Aid:

1. Mail: First Bank & Trust, Attn:Kerri Brand. 110 N Minnesota Ave, Ste 100. Sioux Fall, SD 57104
2. Email: Kerri.Brand@bankeasy.com
3. Fax: 605 .627.1633

**Applications for scholarships must be postmarked no later than June 1,** for consideration for the next school year and must include:

1. All Sections must be completed with signatures
2. Current **official** transcript
   ****INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED****

Award Payments: Trustee shall pay the scholarship grant to the recipient's educational institution with instructions to use the funds to defray the recipient's expenses only if the recipient is enrolled and is in good standing with the purposes and conditions of this grant. If the recipient withdraws from the school after receiving a monetary scholarship award, the scholarship will be terminated and refunds, if any, will revert back to the trust.

Renewal of Scholarship: Selection of award winners by the Scholarship Committee is final. The amount of each award shall be determined by the Scholarship Committee in the exercise of its sole discretion and may vary from time to time and need not be consistent with the amount or amounts paid to other students in similar situations.

Amount and Number of Awards: The scholarship committee shall annually, before school year starts, provide the trustee with the names of students, their addresses, and the schedule of scholarship awards that each

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# WALTER N GRAHAM & DOROTHY D. GRAHAM SCHOLARSHIP FUND APPLICATION

**Applications are due JUNE 1ST.**

Applicant: _____ E-Mail: _____
First Name MI Last Name

Address: _____ Telephone: _____
Street City State Zip

Social #: _____ Occupation: _____ Your Income:_____

Marital Status:_____ Ages of Dependent Children:_____

Parents/Guardian/Spouse occupation:_____ & anticipated Income for current year:_____

How many siblings still living with your parents/guardian:_____

Describe your reasons for choosing a healthcare as a profession and any pertinent information which would be helpful in evaluating your need for this scholarship:

☐ I have been accepted into a nursing program. Name of nursing program: _____

☐ I authorized the nursing education program named above to release information to the South Dakota Board of Nursing to determine eligibility for the Nurse Education Assistance Scholarship.

SIGNATURE OF APPLICANT: _____ DATE:_____

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**NURSING PROGRAM REPRESENTATIVE:** Please complete this section and send to the Financial Aid Office.

☐ I verify this student has been accepted into the nursing major or coursework. ("Pre-nursing" students are not eligible.)

Nursing Education Program:_____ Date Accepted:_____ Expected Graduation Date:_____

Nursing Credits: _____ GPA (Cumulative): _____

Nursing status for upcoming academic year: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior

_____ _____
NURSING PROGRAM REPRESENTATIVE: **PRINT/TYPE NAME** TITLE OR RELATIONSHIP TO STUDENT

_____ _____ _____
NURSING PROGRAM REPRESENTATIVE: SIGNATURE TELEPHONE DATE

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**FINANCIAL AID OFFICER:** Please complete this section and return to the **Student or First Bank & Trust.**

**Estimated Tuition & Fees** for the academic year: _____
**Total Educational Grants** _____
**Total Scholarships** _____
**Total Benefits (Veterans,Social,Other)** _____
**Employment(Federal Work Study,other)** _____
**Family Contributions** _____
**Total Direct Expenses**_____
**Minus Financial Aid** _____
**Unmet Need** _____

_____
FINANCIAL AID OFFICER: SIGNATURE

_____
DATE