

UNIVERSITY OF ROCHESTER MEDICAL CENTER  
STRONG MEMORIAL HOSPITAL  
NURSING PRACTICE

STUDENT ASSISTANCE PROGRAM

APPLICATION PACKET

**[Call (585) 275-3478 for application deadline date.]**

## Application Directions

**Form #1 – Application** must be filled out completely and signed by the applicant.

**Form #2 – Individual Profile** must be type written and no longer than 1 page in length. Applicant must be sure to sign his/her name at the bottom of the essay.

**Form #3 – Employer Recommendation** is to be completed by your current supervisor at your place of employment. Applicant should complete the top section of the form. The form should then be given to your supervisor for completion.

The employer is to return the completed form directly to the Office of Nurse Recruitment and Marketing in the envelope provided by the applicant.

**Form #4- Personal Letter of Recommendation** is to be completed by an individual who can comment on your character and potential contributions to the nursing profession. Applicant should complete the top section of the form. The form should then be given to the individual who will be completing the form. The completed form should be returned directly to the Office of Nurse Recruitment and Marketing in the envelope provided by the applicant.

**Please note: Each applicant must have at least TWO (2) completed recommendation forms - one employer reference (Form #3) and one Personal Letter of Recommendation (Form #4).**

**If the applicant is not currently employed, Form #3 can be omitted and Form #4 can be used instead for the second statement of recommendation.**

**Applicants may submit up to three additional Personal Letters of Recommendation if desired. (Form #4).**

All application forms must be completed and returned **no later than** [call (585) 275-3478 for application deadline date] **to:**

Nurse Recruitment & Marketing  
ATTN: Student Assistance Program  
Box 619-19  
601 Elmwood Avenue  
Rochester, New York 14642

**Application forms received with a postmark dated after the application deadline date will not be considered during the review process.**

Please call (585) 275-3478 if you have questions or need further assistance.

**University of Rochester  
Strong Memorial Hospital  
Nursing Practice**

**STUDENT ASSISTANCE PROGRAM  
APPLICATION**

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number(s): (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

School of Nursing enrolled: \_\_\_\_\_

Date matriculated into Nursing Program: \_\_\_\_\_

Semester/year began coursework toward a Nursing Degree: \_\_\_\_\_

Expected semester/year of program completion: \_\_\_\_\_

Currently attend school:  
 full-time     part-time    If part-time, average number of courses per semester: \_\_\_\_\_

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**If you are currently an employee at the University of Rochester, please complete the following:**

Hire date at the University of Rochester Medical Center: \_\_\_\_\_

Current Department: \_\_\_\_\_

Current Position Title: \_\_\_\_\_

Current Supervisor: \_\_\_\_\_ Telephone: \_\_\_\_\_

How long have you worked in this department? \_\_\_\_\_ Years/Months

How long in this position? \_\_\_\_\_ Years/Months

Currently working \_\_\_\_\_ hours per week. Current wage is \_\_\_\_\_ per hour.

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Are you engaged in any contractual arrangement with another employer of nurses that exchanges financial assistance for employment after graduation?

Yes     No

TO THE BEST OF MY KNOWLEDGE, ALL OF THE ABOVE INFORMATION AND INFORMATION CONTAINED IN THE ATTACHED ESSAY(S) IS TRUE. PLEASE ACCEPT MY FORMAL APPLICATION TO STRONG NURSING'S STUDENT ASSISTANCE PROGRAM.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

University of Rochester  
Strong Memorial Hospital  
Nursing Practice

**\*STUDENT ASSISTANCE PROGRAM\***  
***INDIVIDUAL PROFILE***

In the space provided, or on a separate sheet of paper, please type a brief essay no longer than one page: (1) that describes why you have chosen nursing as a profession and (2) describes your future goals. Be sure to note your work related experiences in the health care field, and personal and/or volunteer experiences that may have lead to your decision to choose nursing as a career.

**I have chosen the nursing profession because:**

**My future goals as a professional nurse are:**

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

University of Rochester  
Strong Memorial Hospital  
Nursing Practice

**EMPLOYER RECOMMENDATION LETTER**

I, \_\_\_\_\_, hereby authorize and request a confidential letter of  
(Signature of Applicant)  
recommendation from \_\_\_\_\_, my current supervisor, for the sole  
(Supervisor's Name)  
purpose of consideration for financial assistance from Strong Memorial Hospital Nursing Practice  
through the Student Assistance Program.

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Please comment on the following criteria:

1. **Initiative in completing work assignments**

- Below Average       Average       Above Average       Outstanding

**COMMENTS:**

2. **Quality of work completed**

- Below Average       Average       Above Average       Outstanding

**COMMENTS:**

3. **Interactions with peers in the work setting**

- Below Average       Average       Above Average       Outstanding

**COMMENTS:**

4. **List of employee's strengths:**

5. **Aptitude for career in nursing based on past employment**

- Below Average       Average       Above Average       Outstanding

**COMMENTS:**

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

In what capacity? \_\_\_\_\_

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Print Name \_\_\_\_\_

Title \_\_\_\_\_

Signature \_\_\_\_\_

Date completed \_\_\_\_\_

Business Name \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone Number \_\_\_\_\_

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Please return this letter to the address noted below.

Nurse Recruitment & Marketing  
**ATTN:** Student Assistance Program  
Box 619-19  
601 Elmwood Ave  
Rochester, New York 14642

University of Rochester  
Strong Memorial Hospital  
Nursing Practice

STUDENT ASSISTANCE PROGRAM  
PERSONAL LETTER OF RECOMMENDATION

I, \_\_\_\_\_, hereby authorize and request a confidential  
(Signature of Applicant)  
letter of recommendation from \_\_\_\_\_, for the sole purpose of  
(Name)  
consideration for financial assistance from Strong Memorial Hospital Nursing Practice through the  
Student Assistance Program.

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Please comment on the applicant's character and identify the potential contributions of this individual to the nursing profession. Additional comments may strengthen the applicant's application.

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

In what capacity? \_\_\_\_\_

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Print Name

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Title

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Signature

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Date Completed

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Business Name

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Business Address

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Business Phone Number

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Please return this letter confidentially to the address noted below.

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