



**UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES COLLEGE OF NURSING
Traineeship Application for SPRING 2010 Funding**

If you are a UAMS College of Nursing graduate student who wishes to request financial assistance to attend school and who meets the following criteria, please complete this form **(and the DHHS Public Health Service Form PHS 2271)** and return to Kimberly Morton, Director of Academic Administration and Informatics (ED II Building, 5/110D), by **Friday, October 30, 2009**.

Fax the completed forms to **(501) 686-8350** (email mortonkimberlyj@uams.edu after you send your fax to ask for an application confirmation) or mail them to: **Kimberly Morton, UAMS College of Nursing, 4301 West Markham St. #529, Little Rock, AR 72205**

* On the DHHS Public Health Service Form PHS 2271 we will fill in item #1 PHS Grant Number and item #20 Support for Period of appointment.

Item #14 FIELD OF RESEARCH TRAINING OR CAREER DEVELOPMENT put the code for Nursing which is: **7500**

Item #15 PERIOD OF APPOINTMENT: **1/11/2010 – 5/14/2010**

Item #23(c) NAME OF PROGRAM DIRECTOR: **Dr. Claudia Barone**

Item #23(d) INSTITUTION'S NAME, ADDRESS AND PHONE#: **UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES COLLEGE OF NURSING, 4301 W. MARKHAM, # 529, LITTLE ROCK, AR 72205; PHONE: 501-686-5374**

If you have any questions, please contact Kimberly Morton (mortonkimberlyj@uams.edu) or (501) 526-6498.

Eligibility Criteria: MNSc or PhD Students in their final 12 months of study who will graduate in May 2010, August 2010, or December 2010. Priority for funding will go to those students graduating in this order: May 2010, August 2010, or December 2010. * *Neither students with a prior master's degree in nursing seeking post-master's certification in another specialty nor UAMS employees receiving the employee discount are eligible to apply for funding.*

1. Contact/ Employment Information: (please write legibly on all blanks):

Name: _____	STUDENT ID # _____
Address: _____	
City/State: _____	County: _____
Zip: _____	E-mail: _____
Home Phone: _____	Work Phone: _____
Place of Employment: _____	County Where Employed: _____

2. Check Specialty:

- | | |
|--|--|
| <input type="checkbox"/> Family Nurse Practitioner | <input type="checkbox"/> Child Health Clinical Specialist/Case Mgr. |
| <input type="checkbox"/> Gerontological Nurse Practitioner | <input type="checkbox"/> Adult Acute Care Nurse Practitioner |
| <input type="checkbox"/> Women's Health Nurse Practitioner | <input type="checkbox"/> Adult Acute Care Clinical Specialist/Case Mgr. |
| <input type="checkbox"/> Pediatric Nurse Practitioner | <input type="checkbox"/> Nursing Administration |
| <input type="checkbox"/> PhD Student | <input type="checkbox"/> Family Psychiatric/Mental Health Nurse Practitioner |

3. Expected date of graduation: _____

4. Please list the courses that you will be registering for in SPRING 2010. NOTE: Your award is based on the number of credit hours you will be taking. Your hours will be verified by the Student Services Office. If the hours do not match what is listed here your award may be reduced or removed.

COURSE NUMBER	COURSE TITLE	NUMBER OF CREDIT HOURS

I have also included **DHHS Public Health Service Form PHS 2271** with this application.

_____ Student Signature _____ Date