NURSE EDUCATION GRANT PROGRAM PROPOSAL
September 1, 2015 – August 31, 2017

(Legal / Official name of the nursing education program)

(Address)

(City) **(State)** **(Zip)**

(Contact Phone) (Contact FAX)

(Contact Person) (Email Address)

Program Type: *(CHECK ONE)*
☐ Pre-Licensure LPN ☐ Pre-Licensure RN ☐ Post-Licensure (BSN Completion or Graduate)

∗ Projected date to implement plan if the grant is awarded. . . . . _____

∗ Total current yearly enrollment capacity of the nurse education program. _____
∗ The number of additional students anticipated to enroll over a 2-year period if grant is awarded. . . . . _____

∗ Total grant amount requested. . . . . _____

Education Program Accreditation: *(circle)*
Is the nursing education program accredited ?..... **YES NO**

If yes, by which accrediting organization?_____
Governmental approval or accreditation by:
Ohio Board of Regents?..... **YES NO**
Ohio Dept. of Education.? ……... **YES NO**
State Board of Career Colleges and Schools?……... **YES NO**
Other? (please list) _____

Partnership Description: *(CHECK ONE)*
☐ Education Program
☐ Patient Centered Medical Home
☐ Community Health Care Agency
☐ Health Care Facility *(SPECIFY Below:)*
☐ Hospital ☐ Nursing Home ☐ County Nursing Home
☐ County Home ☐ Other health care facility:_____.

The undersigned hereby affirms that the information provided in the enclosed documents and documentation are true and I have hereunto set my hand this **___ day of _____2015.**

(Signature) Administrator, Nursing Education Program

Type Name, Credentials and Title