Martha B. Keates Nursing Fellowship Fund

Purpose:
The Martha B. Keates Nursing Fellowship Fund was established by the AtlantiCare Regional Medical Center, Atlantic City Campus Auxiliary, to honor their long time volunteer Martha B. Keates for her valued community service and to support nursing at AtlantiCare Regional Medical Center.

Eligibility:

- Applicants must be graduating high school seniors who are enrolled in a 4-year degree program **OR** have completed the pre-requisites required at an accredited college or university in a nursing studies program.
- Applicants should submit a complete application along with a 250-word essay and any supporting documents by **April 7, 2023**.

Restrictions:
Children and grandchildren of the City Auxiliary for the AtlantiCare Regional Medical Center are ineligible to apply for the fellowship program due to a potential conflict of interest when awards are being considered. Previous Martha B. Keates fellowship recipients may not reapply.

Fellowship Terms & Conditions:
Fellowship recipients must enroll in and attend an accredited college or university with tuition requirements in the academic year following their selection. Verification of enrollment is required. Fellowship funds will be paid via check directly to the accredited college or university in which the student is enrolled. Fellowship funds will not be paid directly, nor reimbursed, to an award recipient. Fellowship funds will be applied toward tuition fees or book purchase and other appropriate educational expenses, as determined by the Martha B. Keates Nursing Fellowship Fund Committee.

Supporting Documents:
We request a copy of your transcripts, including class rank, and two letters of recommendation from a non- relative.

Certification & Release:
All applicants and where appropriate, their parent or guardian, must sign the attached application, certifying that all information is true and complete to the best of their knowledge. Upon submission of the completed application, applicants grant the Martha B. Keates Nursing Fellowship Fund the right to use any information contained in the application for the purpose of promoting and publicizing the fellowship program, or as is legally required or permitted by law.

Funding Information:
A total of one scholarship, in the amount of $4000, will be awarded annually.

Submission of Application:
All complete applications must be received by **April 7, 2023**. Incomplete applications will not be considered. Applications must be sent to:

AtlantiCare Foundation
Attn: Alexis Cannella
1809 Pacific Ave
Atlantic City, NJ 08401

Description of Requirements
Application Form: The applicant must completely fill out the AtlantiCare Regional Medical Center fellowship application. Applications must be signed and dated in the space provided. *Incomplete applications will not be processed.*

Personal Qualities Statement/Community Involvement: The applicant must submit a one or two page legible (preferably typewritten) summary including the following:

High School Students

1. Student leadership activities
2. Honors and/or awards
3. Career goals
4. Community involvement
5. Why the applicant should be awarded this fellowship

Post High School Applicants

1. Adult applicants should submit 3 through 5 as outlined above

Official Transcript/Academic Achievement: An official up-to-date (sealed) transcript of the high school from which the student will graduate must accompany the fellowship application and must be postmarked no later than **April 7, 2023**.

Letters of Recommendation: The applicant must submit two letters of recommendation. It is desired that these letters address the applicant's qualities such as motivation, leadership and commitment. Letters should be submitted with the completed fellowship application form and must be postmarked no later than **April 7, 2023**.

AtlantiCare FOUNDATION

Application for the
Martha B. Keates Nursing Fellowship Program

Name: _____

Mailing Address: _____

City/State/Zip: _____

Telephone #: _____

Email Address: _____

Name of school and nursing program that the applicant is currently enrolled or plans to enter:

_____

Anticipated graduation date: _____

ALL OF THE INFORMATION ON THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I HEREBY GIVE ATLANTICARE REGIONAL MEDICAL CENTER PERMISSION TO USE MY NAME AND PHOTOGRAPH FOR THE PURPOSE OF PUBLIC RELATIONS AND PUBLICATIONS. NOTE: ALL INFORMATION SUBMITTED WILL BE HELD CONFIDENTIAL UNLESS OTHERWISE NOTED.

Applicant Name (print): _____

Applicant Signature: _____ **Date:** _____

If you are a minor, your parent(s)/guardian(s) must sign here:

Signature _____ **Date:** _____

Signature _____ **Date:** _____