



## EMPLOYMENT HISTORY:

LIST ALL PLACES YOU HAVE BEEN EMPLOYED, JOB TITLE AND DATES OF EMPLOYMENT.  
LIST IN REVERSE CHRONOLOGICAL ORDER BEGINNING WITH YOUR PRESENT EMPLOYER.

YEAR \_\_\_\_\_ FROM TO \_\_\_\_\_  
MONTH YEAR MONTH YEAR

EMPLOYER \_\_\_\_\_ APPLICANT'S JOB TITLE \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

YEAR \_\_\_\_\_ FROM TO \_\_\_\_\_  
MONTH YEAR MONTH YEAR

EMPLOYER \_\_\_\_\_ APPLICANT'S JOB TITLE \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

YEAR \_\_\_\_\_ FROM TO \_\_\_\_\_  
MONTH YEAR MONTH YEAR

EMPLOYER \_\_\_\_\_ APPLICANT'S JOB TITLE \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

ILLINOIS REGISTERED NURSE LICENSE NUMBER:

LIST PROFESSIONAL AND COMMUNITY ORGANIZATIONS AND ACTIVITIES:

HAVE YOU APPLIED FOR ADMISSION TO A NURSE PRACTITIONER PROGRAM?  YES  NO IF YES, DATE APPLIED: \_\_\_\_\_

ARE YOU ACCEPTED:  YES  NO (IF YES, INCLUDE A COPY OF THE ACCEPTANCE LETTER.)

NAME OF UNIVERSITY:

SCHOOL ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

IF NO, WHEN WILL YOU BE NOTIFIED OF ACCEPTANCE? \_\_\_\_\_  
DATE

HAVE YOU APPLIED OR RECEIVED ANY SCHOLARSHIPS THAT REQUIRES A SERVICE OBLIGATION:  YES  NO  
NAME OF SCHOLARSHIP PROVIDER AND LENGTH OF SERVICE OBLIGATION. \_\_\_\_\_

WILL YOU SIGN AN AGREEMENT TO PRACTICE IN A RURAL\* COUNTY IN ILLINOIS FOR A PERIOD OF TWO YEARS FOR EACH YEAR FUNDED AFTER GRADUATION:  YES  NO

IF YES, WHERE WOULD YOU PLAN TO PRACTICE: \_\_\_\_\_  
COUNTY

IS THERE AN AGENCY IN THAT COUNTY WHO WOULD BE INTERESTED IN EMPLOYING NURSE PRACTITIONERS:  YES  NO  
AGENCY NAME: \_\_\_\_\_

IF NO NURSE PRACTITIONER JOB IS AVAILABLE IN THE COUNTY LISTED ABOVE, ARE YOU WILLING TO RELOCATE TO ANOTHER COUNTY:  YES  NO

**PLEASE ENCLOSE WITH THIS APPLICATION FORM A ONE PAGE STATEMENT THAT INCLUDES:**

1. WHY YOU WANT TO BECOME A NURSE PRACTITIONER; AND
2. WHY YOU WANT TO PRACTICE IN A RURAL AREA.

**PLEASE ENCLOSE WITH THIS APPLICATION THREE LETTERS OF PERSONAL RECOMMENDATION.**

**ONE SHOULD BE FROM A REGISTERED NURSE.**

✓ COMMENTS BY COUNTY FARM BUREAU PRESIDENT:

✓ DATE OF APPLICATION: \_\_\_\_\_

**MAIL TO:**

RURAL NURSE PRACTITIONER SCHOLARSHIP PROGRAM  
ILLINOIS FARM BUREAU  
P.O. BOX 2901  
1701 TOWANDA AVENUE  
BLOOMINGTON, IL 61701

FAILURE TO PROVIDE THE REQUIRED  
ATTACHMENTS WILL RESULT IN THE  
DISQUALIFICATION OF APPLICANT IN  
CONSIDERATION FOR THE SCHOLARSHIP.