SUNY DOWNSTATE MEDICAL CENTER
STATE UNIVERSITY OF NEW YORK
HEALTH SCIENCE CENTER AT BROOKLYN
UNIVERSITY HOSPITAL OF BROOKLYN

NURSES WHO ARE INTERESTED IN THE TUITION WAIVER PROGRAM MUST COMPLETE THE FOLLOWING ITEMS:

1. Name: _____
   Last First Middle

2. Social Security Number: _____

3. Mailing Address: _____

   _____

4. Telephone Number: Home: _____ Work: _____

5. Employment Status: _____ Full Time _____ Part Time _____ Other

6. Date of Employment at UHB: _____

7. Current Professional License Information:

   #: _____ State: _____

8. Have you previously applied to the SUNY, HSCB, College of Nursing?
   _____ No _____ Yes For entry in 20 _____

9. Are you currently enrolled in the SUNY, HSCB, College of Nursing?
   _____ Yes ____ Non Matriculated _____ Yes ____ Non Preparatory ____ Yes

10. Are you currently enrolled in a College/University? _____ Yes _____ No

    If Yes, Name of College/University: _____

    Program: _____

11. If interested in a Tuition Waiver Program, please indicate:
    a) For entry in 20 _____ Fall _____ Spring _____ Summer _____

    b) Degree Program you wish to pursue: _____

PLEASE SUBMIT THIS INFORMATION TOGETHER WITH YOUR LETTER OF ACCEPTANCE FROM SUNY, HSCB, COLLEGE OF NURSING TO:

INSTITUTE OF CONTINUOUS LEARNING, BOX 1216
FOR FURTHER INFORMATION, PLEASE CALL: 718-270-2983