



**2009 NPHF/Pfizer Community Innovations Awards**

***Applicant Identification Information***

**1. Applicant:**

Name \_\_\_\_\_  
*First MI Last Degree/Certification*

Mailing Address for All Correspondence:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*City State Zip Code*

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Day Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Evening Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_

**2. Status:**  Student  Practicing Nurse Practitioner

*Complete only the section that relates to your status, student or practicing NP.*

**3. Student:**

• Name of Educational Program \_\_\_\_\_

School/College of Nursing \_\_\_\_\_

Address of Program \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*City State Zip Code*

Name of Program Director \_\_\_\_\_

Year of Entry into Program \_\_\_\_\_

Full-time  Part-time (number of credit hours) \_\_\_\_\_

Expected Date of Completion \_\_\_\_\_

• NP Program Specialty

- |  |                                       |   |
|--|---------------------------------------|---|
| <input type="checkbox"/> Acute Care NP | <input type="checkbox"/> Geriatric NP | <input type="checkbox"/> Psych/Mental Health NP |
| <input type="checkbox"/> Adult NP      | <input type="checkbox"/> Neonatal NP  | <input type="checkbox"/> Women's Health NP      |
| <input type="checkbox"/> Family NP     | <input type="checkbox"/> Pediatric NP | <input type="checkbox"/> Other _____            |

• Program Leads to Advanced Degree of (check one)

- |   |   |
|---|---|
| <input type="checkbox"/> Master of Science in Nursing (MSN or MS) | <input type="checkbox"/> Doctor of Nursing Practice (DNP) |
| <input type="checkbox"/> Master of Nursing (MN)                   | <input type="checkbox"/> Doctor of Nursing (DN)           |
| <input type="checkbox"/> Master of Arts (MA)                      | <input type="checkbox"/> Other _____                      |

\_\_\_\_\_  
Name

