

MWHC Associate Scholarship Application
Due Friday, April 17, 2015
Please Print Clearly – Complete ALL Sections

Do not write in this section

Date Received: _____

Name: _____

Name: _____

Date: _____

Employee # _____

Home Mailing Address:

Street _____

City _____ State _____ Zip _____

Best email address: _____

Phone:

Work # _____

Daytime # _____

Name and address of school (*Scholarship checks are made payable to this school*)

Name of school's accrediting body (*See instructions*):

Date you expect to graduate: _____

I currently hold the following degree(s):

- CNA
- LPN
- ADN
- BSN
- MSN
- MBA
- Other _____
- None

Name of program you are enrolled in: _____

I am working towards the following degree(s):

- CNA
- ADN
- BSN
- MSN
- Nurse Practitioner
- MBA
- Other _____

Number of credit hours you anticipate taking during each of the following semesters or quarters:

Fall 2015:

Spring 2016:

Summer 2016:

Scholarship awards are intended for use during the above time period. Failure to do so will result in funds being returned to the Foundation.

Are you a Mary Washington Healthcare Associate and a minimum 0.5 FTE? Yes No

Did you receive a minimum of "Consistent Performer" on your current performance evaluation? Yes No

Have you received disciplinary action in the form of written level or above in the last six months? Yes No

What was your hire date? (*month, day, year*) _____

Please give the entity and department you are working in: _____

What is your job title now? _____

Name of your immediate supervisor _____

Phone number of immediate supervisor _____

The Scholarship Selection Committee reserves the right to award any and all scholarships. All applicants must meet job performance standards through the date this application is reviewed. By signing this application, you verify that the information you have provided is true and accurate.

Applicant's Signature

Date