OHIO ASSOCIATION FOR HEALTHCARE QUALITY
SCHOLARSHIP APPLICATION FORM

Name of Applicant: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Educational Background: _____

CPHQ? Yes ☐ No ☐ Previous Recipient? Yes ☐ No ☐ Year? ____

Other Certifications: _____

Years of experience in Health Care Review/ Coordination of Care? _____

OAHQ Membership District: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Indicate appropriate category:

_____ Published Article (Copy or verification attached)

_____ Poster Session/Paper Presentation (brief description and verification attached)

_____ Educational materials (Copies attached)

_____ Oral Presentation (Verification attached)

I am aware that my name as a Scholarship Recipient and my type of achievement will be published in the OAHQ Quarterly Newsletter.

_____ _____
(Date) (Signature)

OAHQ would like to notify your organization of your award. If this is acceptable, please provide:

Place of employment: _____

Address: _____

Management Contact Name/Title: _____

Mail Scholarship Form to: **Ohio Association for Healthcare Quality**
Program Team Chairperson
P.O. Box 461045
Cleveland, OH 44146-1045

Revised 11/99; 5/01; 11/01; 12/06