Mid-Atlantic Chapter of the WOCN® Society
Educational Scholarship Application Form

The Mid-Atlantic Chapter of the WOCN Society Scholarship Committee is proud to offer scholarship awards for those nurses wishing to attend an Accredited Educational Program. Scholarship applications are accepted once yearly and must reach the Mid-Atlantic Chapter of WOCN chair of the scholarship committee by the due date. Applications may be submitted before program begins.

No information, either via email or US mail, will be accepted after this time - no exceptions. It is the applicant's responsibility to assure that they have met all criteria and that all requested information has been submitted in full.

Fields with * are required. Complete all other fields as appropriate or enter "N/A" if not applicable.

Applicant Information:

***Email Address:** _____

***First Name:** _____ ***Last Name:** _____

***Credentials:** _____

***Address**: _____

***City:** _____ ***State:** _____ ***Zip Code:** _____

***Phone with area code & type:** _____ Home ☐ Work ☐ Mobile ☐

Identify the WOC Program Which You Would Like to Attend:

***Program Name**: _____

***Start/End Dates**: _____ _____

***Program Description**: _____

_____

Financial Impact:

***Expenses:**

Travel: _____ **Mileage:** _____

Registration Fee: _____ **Rooming Expenses:** _____

***Reimbursements:**

Travel: _____ **Mileage:** _____

Registration Fee: _____ **Rooming Expenses:** _____

Have you been awarded any other awards, grants, or scholarships? Yes ☐ No ☐

If yes, enter the amount: _____

Are you eligible to receive or have you received tuition assistance/ reimbursement from your employer?: Yes ☐ No ☐

If yes, enter the amount: _____

***Financial Need Narrative:**

Explain your financial need / reason for requesting a scholarship:

Employment History

(1) Employer Name: _____

Location: _____

From: _____ **To:** _____

Position/Title: _____

Position Description: _____

_____

_____

(2) Employer Name: _____

Location: _____

From: _____ **To:** _____

Position/Title: _____

Position Description: _____

_____

_____

(3) Employer Name: _____

Location: _____

From: _____ **To:** _____

Position/Title: _____

Position Description: _____

_____

_____

Education Background (begin with most recent)

(1) Institution: _____

City/State/Country: _____

Graduated (mo/yr): _____ **Degree Earned**: _____

(2) Institution: _____

City/State/Country: _____

Graduated (mo/yr): _____ **Degree Earned**: _____

(3) Institution: _____

City/State/Country: _____

Graduated (mo/yr): _____ **Degree Earned**: _____

Upon Completion of Your Program:

How many hours per week do you anticipate working with people having wound, ostomy, or continence needs?: _____

What will be your employment status?: Full Time ☐ Part Time ☐ Unknown ☐

In what type of practice setting will you be working?

Acute Care ☐ Outpatient/Clinic ☐ Home Care ☐ Long Term Care ☐

Industry ☐ Unknown ☐

Will your primary care responsibilities fall within the scope of WOC nursing practice?
(explain anticipated responsibilities)

Anticipated Role: (check all that apply)

WOC Nurse ☐ Consultation ☐ Direct Care ☐ Education ☐
Product Development ☐ Research ☐ Policy and Procedure Development ☐
Other ☐

Describe Anticipated Role:

Describe or provide examples of your contributions to professional and community organizations:

Write a brief summary of your long term career goals. Provide specific reasons for wanting to take this training.

Describe your professional and personal strengths and/or attributes that will enable you to achieve your goals and enhance your role as a WOC nurse.

Signature: _____ **Date:** _____

Please submit completed form to midatlanticwocn@gmail.com.