

# Healthcare Career Education Grant Application



## General Information

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

\_\_\_\_\_

Date of birth \_\_\_\_\_

\_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

\_\_\_\_\_

Email address \_\_\_\_\_

### Requirements for Submission Checklist (For applicant use only)

- Completed application
- Verifiable documentation of acceptance into institution and program of study
- Verifiable documentation of total program expenses
- Verifiable documentation of core courses in program of study and projected dates of enrollment
- Verifiable documentation of institution and program accreditation; copy of most recent transcript (can be unofficial)
- Professional recommendation
- Academic recommendation
- State W-4 Form
- Federal W-4 Form

## Education Information

\_\_\_\_\_

Name of program \_\_\_\_\_

\_\_\_\_\_

School/Institution \_\_\_\_\_

\_\_\_\_\_

Program start date \_\_\_\_\_ End date \_\_\_\_\_

- LEVEL OF EDUCATION**    Certificate    Associates  
 Bachelors    Masters    Doctorate

4. Are you currently employed by Memorial Health?  
 Yes    No
5. If no, do you have immediate family members who work for Memorial Health?  
 Yes    No
6. What additional information would you like us to know when reviewing and considering your application?

## Education Objective and Career Goals

1. How do you foresee the completion of this degree contributing to the strategic needs of Memorial Health?
2. Why did you select this academic institution and program?
3. Are you eligible to receive any grant or scholarship funds outside of the organization for your degree program?  
 Yes    No

## Financial Request

SUMMARY OF PROGRAM EXPENSES

Tuition \_\_\_\_\_

Books \_\_\_\_\_

Fees \_\_\_\_\_

**Total dollars requested** \$ \_\_\_\_\_

I HAVE READ AND UNDERSTAND THE HEALTHCARE CAREER EDUCATION GRANT POLICY.