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 ○ Associate ○ Bachelor's ○ Master's ○ Doctorate

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**

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?

Financial Request

SUMMARY OF PROGRAM EXPENSES

Tuition ______________________________

Books ______________________________

Fees ______________________________

Total dollars requested **$**