



Center for Excellence in Nursing Scholarship
APPLICATION & LETTER OF AGREEMENT FOR TEAM MEMBERS

Scholarship Application

Today's Date _____

Home Facility: (circle one) LRMC TVRH

Applicants Name: _____ ID # _____

Street address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Current Dept: _____ Position: _____

Status: FT PT Pool/PRN Date of Employment: _____

What degree or training program are you pursuing?

RN BSN MSN Other: _____

What school are you planning on attending? _____

Have you applied for admission? Yes / No Have you been accepted into the program? Yes / No If no, when will you know if you have been accepted?

Have you applied for other funding? Yes / No If so, please explain:

Brief explanation of why you are entering this program:

Brief explanation of why you are requesting this scholarship:

The Foundation will review your application for your scholarship assistance. The Foundation will cover the cost of the tuition, books, and medical equipment/supplies up to \$2,000.00 for your program. In return, the Central Florida Health Alliance will require you to agree to fulfill (2) years of full time employment with the Alliance upon successful completion of your program

Do you foresee any reason why you would be unable to meet these requirements? Yes / No

If yes, please explain: _____

To complete this application, please attach the following documents:

___ Employee in good standing form received from HR(no disciplinary action in the last 12 mo.)

___ Letter of recommendation from your supervisor

___ Community Involvement/ Volunteer hours

Applicant's Signature: _____ Date: _____

Please forward the completed application and supporting documents to:

Ted Williams, CEO

Alliance Healthcare Foundation

1501 US Hwy 441, Bldg. 1800, Suite 1802

The Villages, FL 32159

Phone: 352-751-8819 Fax: 352-751-8969

twilliams@cfhalliance.org

By accepting this scholarship, the applicant also acknowledges they have a responsibility to serve as an ambassador for the Foundation at various Foundation events on an as-needed basis.

I have read and agree with the Scholarship program criteria as outlined and I agree to fulfill the employment obligation to LPMC/TVRH upon satisfactory completion of my course of study. If I am unable to complete my service obligation for any reason, I agree to reimburse the percentage of my financial assistance equal to the percentage of time remaining in the work agreement.

Signature of Applicant: _____ Date: _____

The Central Florida Health Alliance Foundation agrees to provide prospective financial assistance in return for a service agreement as defined in the Scholarship program criteria.

Foundation CEO

Date

Scholarship Committee Representative

Date

The initial program was generously provided by The Phoenix Physicians Group