GRACE HOSPITAL
SCHOLARSHIP APPLICATION FORM

Please refer to Scholarship Fund Criteria document for eligibility criteria. Incomplete applications will not be considered.
Questions? Contact **Educational Resources** at ext. #70346

SECTION I (To be completed by applicant)

Name: _____ Home Phone #: _____

Home Address: _____

Email address: _____

Position: _____ Department/Unit: _____

EMPLOYMENT:

☐ Grace Hospital Employee ☐ WRHA Employee sited at the Grace Hospital

COURSE DESCRIPTIONS and TUITION:

COURSE NAME/NUMBER	COURSE START DATE	COURSE END DATE	COURSE TUITION

Describe how the above course will contribute to your performance in your current position or in a job change that you are considering (specify the job): _____

_____

_____

Is this course part of an educational program? (Certificate, Baccalaureate Degree, Master's Degree, etc.)
☐ NO ☐ YES, please specify _____ When do you expect to complete requirements? _____

TUITION AMOUNT PAID:

Total tuition paid for courses listed above: $_____

Please attach a statement from the educational institute indicating the name, dates, and amount of tuition paid for each course and original receipt(s) demonstrating proof of payment.

PREVIOUS FUNDING:

Have you received finding for this course from another source? ☐ NO ☐ YES (amount) $_____

Have you received previous grants from the Grace Hospital Scholarship Fund? ☐ NO ☐ YES (Year)_____

CONTRACT:

If awarded a grant I understand that the funds will be paid to me only after I submit a course transcript showing successful completion of the course. I understand I need to submit my transcript and receipts within two months of completion of course or from the date of the approval letter, whichever is later.

If awarded a grant of $300 or more, I am prepared to remain actively employed at Grace Hospital for a period of one (1) year following approval of the grant.

If I leave Grace Hospital before completing this length of service, I agree to repay a portion of the Scholarship Fund Grant and hereby authorize Grace Hospital to make any necessary deductions from any final pay owing to me. (Waived if employee is laid-off).

Applicant's Signature _____ Date: _____

Please forward this application to your manager to obtain required signatures on reverse side of this form.

SECTION II - DEPARTMENTAL APPROVAL (To be completed by Manager and Director)

A. Indicate the value of this applicant taking this particular course - CHOOSE ONE ONLY:

- ☐ Applicant is required by the Grace or the WRHA to take course to maintain their position.
- ☐ The course has immediate applicability to the current job and any new skills acquired will enhance service delivery at the Grace Hospital.
- ☐ The course will prepare the person for a different job in health care at the Grace Hospital.

B. Do you support this application: ☐ NO ☐ YES

Comments: _____

_____

_____

_____	_____	_____
Manager Name (Please print)	**Manager Signature**	**Date**
_____	_____	_____
Director Name (Please print)	**Director Signature**	**Date**

ONCE COMPLETED, PLEASE FORWARD TO EDUCATION RESOURCES PRIOR TO DEADLINE.

SECTION III - ADMINISTRATION SECTION (To be completed by Scholarship Fund Committee)

☐ **Approved:** _____ **Amount Awarded**

☐ **Not Approved**

Comments: _____

_____

_____

_____	_____
COO Signature	Date

Date Cheque Processed: _____

Finance: Amount on cheque request must equal **Amount Awarded.**
Required: Payment receipt, course description, & proof of successful completion must be provided prior to payment.