

SCR – WOCN Beverly G. Hampton Memorial Scholarship Application

ELIGIBILITY CRITERIA

1. A registered nurse residing in one of the SCR WOCN states (AR, LA, MS, OK, TX).
2. Seeking education in wound, ostomy, and continence nursing at M. D. Anderson WOC Nurse Education Program (WOCNEP).
3. Proof of one of the following:
 - Acceptance in the M. D. Anderson WOCNEP.
 - Current enrollment in the M. D. Anderson WOCNEP.
 - Certificate of completion of the M. D. Anderson WOCNEP within the last 3 months.

CHECK LIST

This check list of **mandatory** components is provided for your convenience.

Submit a copy of your application including the following components:

- Completed, legible application
- Signed consent forms
- Acceptance letter, proof of current enrollment or certificate of completion from the M. D. Anderson WOCNEP.
- Three letters of recommendation

Application must be received by the SCR WOCN Scholarship Chair by November 1st. The SCR WOCN Scholarship Committee will review completed legible applications. A written response can be expected within 8 weeks of the deadline for submission. It is advisable to keep a copy of your completed application packet.

Completed application packet may be mailed, faxed, or sent electronically to the following:

Tabatha Schroeder
8611 Aggie Ln.
Needville, TX 77461
Cell: 832-344-7556

tabatha.schroeder@molnlycke.com

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GUIDELINES FOR LETTERS OF RECOMMENDATION

Applicant: Please give this form to those individuals from whom you have requested a letter of recommendation.

The SCR WOCN Scholarship Committee awards scholarships to deserving individuals committed to working within the wound, ostomy and continence specialty. You have been identified by this applicant to provide a letter of recommendation for a financial award.

It would be helpful if you could speak to the utilization of this applicant's WOC education and the patient population to be served in your community. Please address any of the following attributes to assist the committee in the evaluation of this applicant.

- professionalism
- commitment
- communication skills
- problem solving skills
- leadership ability
- critical thinking ability

Thank you,
The SCR WOCN Scholarship Committee

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APPLICATION FORM

Return a completed copy of this application to: Marcia Davis, MS, RN, CSN-CWOCN
416 Kensington Rd
Norman, OK 73072
(405) 307-6955 (W) (405) 360-7388 (H)
mdavis@diversifiedcs.com
(405) 307-6957 (FAX)

All information will be kept confidential

Leave no Blanks

Please remember that incomplete or illegible applications will not be reviewed.

Applicant Information

1. Name:	
Address:	
City/State/Zip	
Phone: Home ()	Work ()
2. Social Security Number:	
3. Start date of the M. D. Anderson WOCNEP into which you were accepted:	
4. Type and content of the program you selected:	
Type:	<input type="checkbox"/> On Site <input type="checkbox"/> Split Option <input type="checkbox"/> Home Study
Content: (Check all that apply)	<input type="checkbox"/> Wound <input type="checkbox"/> Ostomy <input type="checkbox"/> Continence

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A. Financial Information

5. What is your total annual net household income (take-home pay)?	\$ _____
6. What is your contribution to the household income?	\$ _____
7. How many dependents did you claim on most recent Federal Tax Form 1040?	\$ _____
8. Will you lose income while completing the M. D. Anderson WOCNEP? <input type="checkbox"/> Yes <input type="checkbox"/> No Estimate loss (if applicable)	\$ _____
9. Have you been awarded any other scholarships? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount (if applicable)	\$ _____
If yes, please specify source of award/scholarship.	

10. How are you planning to pay for your WOC education?	

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11. What are your Nursing Education Program costs and reimbursements?

Costs		Reimbursements	
Airfare	\$ _____	Airfare	\$ _____
Mileage*	\$ _____	Mileage*	\$ _____
Tuition	\$ _____	Tuition	\$ _____
Books	\$ _____	Books	\$ _____
Room/Lodging	\$ _____	Room/Lodging	\$ _____
Meals**	\$ _____	Meals**	\$ _____
Proctor/Preceptor	\$ _____	Proctor/Preceptor	\$ _____
Copying/Postage	\$ _____	Copying/Postage	\$ _____
Total	\$ _____	Total	\$ _____

*Calculate using current federal mileage rate

** While living away from home – not to exceed \$20/day

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B. Nursing Practice Demographic Information

14. What is the anticipated number of hours per week that will be spent meeting the needs of people with wounds, ostomies, or incontinence? _____
15. What will be your employment status upon completion of your education program?
- a. Practice Setting (acute care, home care, etc.) _____
- b. Will your primary care responsibilities be within the scope of WOC nursing?
- Yes No

Please explain:

- c. If not currently employed, how do you plan to incorporate WOC nursing into your practice?

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C. Professional Work Credentials/Experience

16. Employment history (begin with most recent)			
Employer: _____			
Name	City/State	Dates	
Position Description: _____			

Employer: _____			
Name	City/State:	Dates	
Position Description: _____			

Employer: _____			
Name	City/State:	Dates	
Position Description: _____			

17. Educational Background:			

Institution	City/State	Date graduated	Degree

Institution	City/State	Date graduated	Degree

Institution	City/State	Date graduated	Degree

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18. List the professional/community organizations to which you belong. (Include offices held and committee participation)

19. List the professional journals to which you subscribe or read regularly.

20. List your professional awards or honors.

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24. Write a brief statement of your long-term career goals.

25. I hereby certify that this is a true and accurate representation of data and my activities and accomplishments.

Signature: _____

Date: _____

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AGREEMENT FORMS

Consent for Name Release

The SCR WOCN may use your name during the scholarship application process. Examples of this may include contacting the Director of the M. D. Anderson WOCNEP; sharing your application with other SCR WOCN Scholarship Committee members for review; and checking references to determine your eligibility. Please sign this consent form. All information will be kept confidential.

I, _____, hereby give permission for the release of my name and address to determine my scholarship eligibility during the review process and, in the event that I am awarded the Beverly G. Hampton Memorial Scholarship, my name may appear in the SCR WOCN e-news, press releases, or other publications of the WOCN.

Signature

Date

Scholarship Agreement Form

I, _____, hereby agree to the policy established by the SCR WOCN Scholarship Committee. In the event I am unable to attend the M. D. Anderson WOCNEP within one year of receipt of a scholarship, all monies heretofore accepted by me will be forfeited and returned to the SCR WOCN Treasurer. Should I be selected as a recipient of the Beverly G. Hampton Memorial Scholarship, I will join WOCN if not currently a member.

Signature

Date