

## ROCKY MOUNTAIN CHAPTER OF THE WOCN® SOCIETY SCHOLARSHIP APPLICATION FOR WOC NURSE RECERTIFICATION

Date of	Application:	
First Name:		Last Name:
Credent	ials:	
		Zip Code:
Phone:		Alternate Phone:
Email:		Alternate Email:
Employer:		Job Title:
Employer Phone #:		Supervisor:
Yes If so, inc	No dicate the amou	st you with certification/recertification fees?  nt your employer will assist:
_		ncial assistance from the RMC in the last 3 years?
Yes	No	If yes, date:
-	provide any other	er information you would like the RMC to be aware of when ation:





I have emailed 2 letters of reference from a Professional Colleague (WOC Nurse preferred) or Supervisor to rmrwocn@gmail.com.

I hereby affirm that the information provided by me is true to the best of my knowledge, and I will notify the RMC of WOCN of any changes to this information.		
Signature:		
You are required to submit a copy of your receipt of payment and your new certification award. Scholarship will be presented after the RMC Board of Directors has received verification that you have completed and passed the certification exam(s)		

\*The RMC reserves the right to audit any application for a period of up to one year from the date of any award.