

Southeast Chapter of the WOCN® Society Conference Scholarship Application

Application Form:

* Denotes required fields

*Email Address: _____

*First Name: _____

*Last Name: _____

*Credentials: _____

*Address: _____

*City: _____ *State: _____ *Zip Code: _____

*Phone with area code & type: _____

Home Work Mobile

*Certification: _____

*WOCN Member ID #: _____

*Southeast Chapter Member? Yes No

*Employment Status:
Full Time Part Time Other

Describe if other:

*Employer: _____

*Title or Role: _____

*Percentage of Funding Your Employer will provide: (Applicants who receive funding from employer for conference expenses may not qualify for scholarships.)

0% 25% 50% 75% 100% Other

Describe if other:

*Describe how attending this event will impact your WOC nurse practice: (300 words or less)

Last 3 conferences attended and funding received (if any)

Conference Name: _____

Conference Year: _____ Money Received: _____

Conference Name: _____

Conference Year: _____ Money Received: _____

Conference Name: _____

Conference Year: _____ Money Received: _____

Scholarship recipients will be solely responsible for all federal, state and/or local taxes associated with the scholarship. In the event, a recipient receives an amount of \$600 or more, they will be required to sign tax documents (W-9 form) BEFORE receiving scholarship payment.

In lieu of my signature, completing this information, I hereby certify that this is a true and accurate representation of my information, activities, and accomplishments.

Type Full Name: _____

Today's Date: _____

Please submitted completed form to: manager@serwocn.org.