Southeast Chapter of the WOCN® Society
Dorothy Doughty Education Scholarships
WOC Nursing Education Program (WOCNEP) 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

*WOCN Member ID #: _____

*Southeast Chapter Member? ☐ Yes ☐ No

*Identify the WOCNEP which you are accepted and plan to attend:_____

_____

Program Start Date: _____ Program End Date: _____

*Employment Status:
☐ Full Time ☐ Part Time ☐ Other

Describe if other:

_____

_____

_____

*Employer: _____

*Title or Role: _____

**Identify the type of program (full scope or specialty) in which you would like to enroll:

_____

Financial Impact – Expenses:

Travel (Airfare): _____

Mileage (@prevailing IRS rate): _____

Tuition: _____

Lodging: _____

* Have you been awarded any other funds for your WOC Educational Program?

☐ Yes ☐ No

*Are you eligible to receive tuition assistance / reimbursement from your employer?

☐ Yes ☐ No

Describe your employer's tuition assistance program, and your plans to access these funds:

_____

_____

_____

*Have you received tuition assistance / reimbursement from your employer? ☐ Yes ☐ No

If yes, how much? _____

***Employment History (begin with most recent)**

Employer1:

Name: _____

Location: _____

From: _____ To: _____

Describe Position / duties performed: _____

_____

_____

_____

Employer2:

Name: _____

Location: _____

From: _____ To: _____

Describe Position / duties performed: _____
_____
_____
_____

Employer3:

Name: _____

Location: _____

From: _____ To: _____

Describe Position / duties performed: _____
_____
_____
_____

***Education Background (begin with most recent)**

Education1:

Institution Name: _____

Location: _____

Graduated: _____ Degree Earned: _____

Education2:

Institution Name: _____

Location: _____

Graduated: _____ Degree Earned: _____

Education3:

Institution Name: _____

Location: _____

Graduated: _____ Degree Earned: _____

Upon Completion of your educational program:

How many hours / week do you anticipate working with people having WOC or foot care needs?

_____
_____

What will be your employment status?

☐ Full Time ☐ Part Time ☐ Unknown

In what type of practice setting will you be working?

☐ Acute Care ☐ Long Term ☐ Home Care ☐ Industry

☐ Unknown ☐ Outpatient/Clinic

Describe your anticipated role / activities as a WOC nurse (check all that apply)

☐ WOC nurse ☐ Direct Care ☐ Consultation ☐ Education ☐ Research

☐ Product Development ☐ Policy/Procedure Development ☐ Other

If other, please describe: (300 words or less) _____

Describe or provide examples of your contributions to professional and community organizations: (300 words or less)

List continuing education courses, programs and/or other professional development activities related to WOC nursing completed in the last two years: (300 words or less)

Write a brief summary of your long term career goals. Provide specific reasons for wanting to take this training: (300 words or less)

Describe your professional and personal strengths and/or attributes that will enable you to achieve your goals and enhance your role as a WOC nurse: (300 words or less)

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.

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