CARESPRING HEALTH CARE MANAGEMENT

EDUCATION OPPORTUNITIES APPLICATION:

GENERAL SCHOLARSHIP OR CHRIST COLLEGE OF HEALTH SERVICE SCHOLARSHIP / TUITION REIMBURSEMENT or LOAN REPAYMENT PROGRAMS

Thank you for your interest in applying for an educational award opportunity with Carespring. Please complete the following for submission:

1. **Team Members - Complete this application.** Once complete, please choose File > Save As, then save to your computer with your name in the title and send completed document to your FACILITY ADMINISTRATOR
2. **Recommendation** - Have your facility administrator complete the last page and have Administrator submit it to barbmc@carespring.com
3. **Financial Need** - Attach your financial need information or statements to allow the committee to review your needs

PERSONAL INFORMATION

LAST NAME: FIRST NAME:

STREET ADDRESS:

CITY: STATE:

ZIP CODE: LAST 4 OF SSN

EMAIL ADDRESS:

PHONE NUMBER:

DATE OF BIRTH:

ARE YOU APPLYING AS A TEAM MEMBER?

IF YOU ARE APPLYING AS A FAMILY MEMBER, WHO IS YOUR RELATIVE?

If you are a team member, please complete the next 3 questions:

WHAT IS YOUR HOME FACILITY?

ARE YOU FULL TIME or PART TIME?

WHAT IS YOUR DATE OF HIRE?

WHICH PROGRAM ARE YOU APPLYING FOR?:

WHAT EDUCATIONAL OPPORTUNITIES ARE YOUR SEEKING?

You must be a Full or Part Time employee or family member of such that has been employed for at least the last consecutive 3 months (Exceptions could be Nursing Student Who Agree to Loan Repayment Program)

CURRENT, FUTURE AND PRIOR EDUCATION

List your current and previous schools, beginning with the most recent:

NAME OF CURRENT OR FUTURE COLLEGE /INSTITUTION:

MAJOR and DEGREE:

START DATE:

ANTICIPATED END DATE OR GRADUATION DATE:

G.P.A. IF ALREADY ATTENDING:

NAME OF PRIOR COLLEGE/INSTITUTION:

MAJOR and DEGREE:

START DATE:

ANTICIPATED END DATE OR GRADUATION DATE:

G.P.A.

DO YOU CURRENTLY
HAVE A DEGREE (IF YES,
LIST IT. IF NO, LEAVE
BLANK:

NAME OF HIGH SCHOOL:

EXPECTED/ACTUAL
GRADUATION (Month/Year)

G.P.A.:

WHY DO YOU THINK WE SHOULD ASSIST YOU WITH YOUR CURRENT OR PAST
EDUCATIONAL NEEDS? **PLEASE COMPLETE THIS SECTION.**

Facility Administrators to Complete this Section:

Please complete the below for the applicant and once completed, please submit entire application to barbmc@carespring.com.

Team Member Name:

Is Team Member Full Time, Part Time or PRN? (PRN are not eligible):

Has Team Member worked at least 24 hours per week for the last consecutive 3 months?

How many attendance points does the team member have? (must be under 12 points to be considered)?

Is employee up to date on all assigned Relias courses?

Is team member in good standing?

Did team member submit current financial need information or statements?

Do you recommend the team member for this program? (Please explain):

Administrator/Department Head Name that is completing the above recommendation:

Administrator/Department Head Signature:

Date: