# Center for Excellence in Nursing Scholarship

*APPLICATION & LETTER OF AGREEMENT FOR TEAM MEMBERS*

Today's Date: ______________________ Home Facility: (circle one) LRMC TVRH

Applicants Name: ________________________________ ID # ______________________________

Street address: ___________________________________________________________________________

City: ____________________________________ State: ________ Zip: ________________

Home Phone: (____) ______________ Cell: (____) ______________ Email: ______________________

Current Dept: _____________________________ Position: _________________________________

Status: (circle one) FT PT Pool/PRN Date of Employment: ______________________

What degree or training program are you pursuing? RN BSN MSN Other: _______________

What school are you planning to attend? _____________________________________________________

Have you applied for admission? ☐ Yes ☐ No Have you been accepted? ☐ Yes ☐ No

If no, when will you know if you have been accepted? ___________________________________________

Have you applied for other funding? ☐ Yes ☐ No

If yes, please explain: _________________________________________________________________

Brief explanation of why you are entering this program: ______________________________________

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Brief explanation of why you are requesting this scholarship: ______________________________

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The Foundation will review your application for scholarship assistance. The Foundation will cover the cost of tuition, books, and medical equipment/supplies up to $2,000.00 for your program. In return, Central Florida Health will require you to agree to fulfill (2) years of full time employment upon successful completion of your program. Do you foresee any reason why you would be unable to meet these requirements?

☐ Yes ☐ No

If yes, please explain: ______________________________________________

______________________________________________________________________

______________________________________________________________________

To complete this application, please attach the following documents:

☐ Employee in good standing form received from HR (no disciplinary action in the last 12 mo.)

☐ Letter of recommendation from your supervisor

☐ Community Involvement / Volunteer hours (minimum of 4 hrs – attach documentation)

**Applicant's Signature:** ________________________________ **Date:** ______________

**Please forward the completed application and supporting documents to:**
Ted Williams, President
Leesburg Regional Medical Center Foundation
701 N. Palmetto Street, Suite G
Leesburg, FL 34748
Phone: 352-323-5502
Fax: 352-323-5509
twilliams@centflhealth.org

By accepting this scholarship, the applicant also acknowledges they have a responsibility to serve as an ambassador for the Foundation at various Foundation events on an as-needed basis.

I have read and agree with the Scholarship program criteria as outlined and I agree to fulfill the employment obligation to Central Florida Health upon satisfactory completion of my course of study. If I am unable to complete my service obligation for any reason, I agree to reimburse the percentage of my financial assistance equal to the percentage of time remaining in the work agreement.

**Signature of Applicant:** ________________________________________ **Date:** _______________

The Leesburg Regional Medical Center Foundation agrees to provide prospective financial assistance in return for a service agreement as defined in the Scholarship program criteria.

________________________________________ ____________________

Foundation President Date

________________________________________ ____________________

Scholarship Committee Representative Date Date

**The initial program was generously provided by The Phoenix Physicians Group**