South Central PA Affiliate of the Northeast Region
WOCN® SCHOLARSHIP APPLICATION

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

WOCN® Education Program (WOCNEP) enrolled: _____

Specialties enrolled in partial or full scope wound/ostomy/continence:

_____

Employer: _____

Amount of financial support from employer or other professional organizational scholarships:

_____

Date program starts: _____Cost of program: _____

Date of anticipated completion of program: _____

*If a scholarship is awarded, funds will be provided as follows: ¾ of the determined amount initially and the other ¼ at completion of program to go towards an Affiliate Membership of the WOCN.

Signature: _____ Date: _____

*PLEASE print and sign this Application and attach this signed form and the following documents attached as PDFs and email to southcentralpaaffiliate@gmail.com with "Scholarship Committee" in the Subject Line.

Please include:

1. The completed and signed Application.
2. A personal statement of professional goals describing your interest in the discipline (100-150 words).
3. A letter of acceptance from your WOCNEP indicating which specialty or specialties you have been accepted for.
4. **Two** letters of recommendation from a professional associate or current employer to support your commitment to the WOCN® profession.