Tennessee Public Health Association

Application for Scholarship Award
(Please type or print clearly.)

Name: ______________________________________________

Home Address ____________________________________________________________________

Place of Employment: ______________________________________________________________

Phone: (Home) _________________ (Office) ________________ E-mail: ____________________

Professional Category: ______________________________________________________________

Public Health Employment History:

Current Position: _______________________ Date From: ____________ To: ____________
Responsibilities: _________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Current Position: _______________________ Date From: ____________ To: ____________
Responsibilities: _________________________________________________________________
_____________________________________________________________________________

Current Position: _______________________ Date From: ____________ To: ____________
Responsibilities: _________________________________________________________________
_____________________________________________________________________________

Current Position: _______________________ Date From: ____________ To: ____________
Responsibilities: _________________________________________________________________
_____________________________________________________________________________
Professional Registrations or Licenses Held:

<table>
<thead>
<tr>
<th>License or Registration</th>
<th>State</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>_________________________</td>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>_________________________</td>
<td>_______</td>
<td>_______</td>
</tr>
<tr>
<td>_________________________</td>
<td>_______</td>
<td>_______</td>
</tr>
</tbody>
</table>

Education:

<table>
<thead>
<tr>
<th>Institution and Address</th>
<th>Degree/Diploma Earned and Field of Study</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>_________________________</td>
<td>____________________________</td>
<td>_______</td>
</tr>
<tr>
<td>_________________________</td>
<td>____________________________</td>
<td>_______</td>
</tr>
<tr>
<td>_________________________</td>
<td>____________________________</td>
<td>_______</td>
</tr>
</tbody>
</table>

Amount of Scholarship requested: ____________________________

Would less than requested amount prevent goal attainment? __________

Do you anticipate receiving financial assistance from other source(s)? __________

If so, how much and from whom? ____________________________

Type of training planned: __________________________________________

__________________________________________________________

Number of credit hours or CEU’s to be awarded: ____________________________

Have you been accepted for training by an accredited education institution? If applicable, Yes _____

No _____ Uncertain ________ If uncertain, when will you know? ____________________________

What educational institution: __________________________________________

Address: __________________________________________________________________________

(Please attach a copy of program announcement or course description from college catalog.)

Are you a member of TPHA? Yes _______ No _______ If yes, how long? __________
Financial reasons for requesting scholarship (be specific): ______________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

What contributions do you feel you have made to public health? __________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Expected achievement from training and future professional plans: _________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Please add additional information you feel is pertinent to the rating of this application: ______________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Include at least one (1), but no more than three (3), letters of recommendation from someone who has
knowledge of your professional development.

Signature ___________________________________________ Date ________

Supervisor ___________________________________________ Date ________

The Scholarship Committee shall make recommendations to the TPHA Executive Committee and the
total awards will have to be within the limits of available funds.
Tennessee Public Health Association Scholarship

Letter of Agreement

Upon receipt of a Tennessee Public Health Association scholarship, I, ________________________, agree to continue my employment with a Public Health Agency in Tennessee for at least one (1) year upon completion of program or course work for which the money was provided.

If unable to complete this obligation, I will reimburse the Tennessee Public Health Association scholarship fund the full awarded amount within six months.

I further agree to complete the course for which the scholarship is being awarded or return the money to the Tennessee Public Health Association.

________________________________________
Recipient

________________________________________
Date

(This form must be notarized and returned to the Tennessee Public Health Association.)