

# Tennessee Public Health Association

## Application for Scholarship Award

*(Please type or print clearly.)*

***Incomplete applications will not be considered.***

Name: \_\_\_\_\_

Home Address \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Office) \_\_\_\_\_ E-mail: \_\_\_\_\_

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:

License or Registration	State	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Education:

Institution and Address	Degree/Diploma Earned and Field of Study	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Amount of Scholarship requested: \_\_\_\_\_

(\$1,000 limit for degree programs, \$500 limit for certificate programs)

Would less than requested amount prevent goal attainment? \_\_\_\_\_

Have you applied for any other TPHA Scholarships this year? \_\_\_\_\_

Have you received any other TPHA Scholarships in the past? \_\_\_\_\_

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

If so, how much and from whom? \_\_\_\_\_

Have you been accepted for training by an accredited education institution?

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.)

Type of training planned:

☐ Degree Program ☐ Certificate Program ☐ Other (Please specify)

Number of credit hours or CEU's to be awarded: \_\_\_\_\_

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.

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Recipient

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Date