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:

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<th>License or Registration</th>
<th>State</th>
<th>Date</th>
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Education:

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<th>Institution and Address</th>
<th>Degree/Diploma Earned and Field of Study</th>
<th>Date</th>
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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 CEUs 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.

__________________________________________
Recipient

__________________________________________
Date