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: ________________________________

Current Position: __________________________ Date From: ___________ To: ____________
Responsibilities: ________________________________
Professional Registrations or Licenses Held:

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

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<tr>
<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 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.

________________________________________
Recipient

________________________________________
Date

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