HAROLD AND EDNA BRAGG HEALTHCARE EDUCATION SCHOLARSHIP
CONTINUING EDUCATION
(Do not use this form for college credit classes.)

The Harold and Edna Bragg Healthcare Education Scholarship Funds are provided by income derived from initial capital investments made at the request of Edna Bragg. These were in an endowment to the Foundation in 1992 during the "Commitment to Caring" campaign and in a bequest in her will after her death in 1995.

Continuing education funds are provided to a resident or employee in the Lake Chelan area continuing their education as a healthcare professional. This application is to be completed for workshops, seminars, conferences or a course that enhances the applicant's healthcare education/career. No money is available for retroactive funding. All applications must be turned in before classes begin, preferably six-weeks prior to the event. Checks are ordinarily made to the education provider unless other arrangements are made.

1. **ELIGIBILITY REQUIREMENTS FOR CONTINUING EDUCATION FUNDS – APPLICANTS:**
   a. Must have lived or worked in the Lake Chelan area a minimum of one year.
   b. Must plan to attend an accredited class or training certified by the Lake Chelan Community Hospital, a professional certification agency and/or Washington State.
   c. Must submit a course description and cost breakdown. Please include a copy of registration form with application.
   d. Must provide written, signed and dated recommendation from supervisor (or other appropriate person if applicant is unemployed).

2. **USE OF FUNDS**
   a. Funds awarded are usually for registration fees.
   b. In some cases, other expenses may be allowed at the discretion of the scholarship committee and/or availability of funds.

3. **PROCEDURES**
   a. Submit completed application and any other required materials to Lake Chelan Health & Wellness Foundation, P. O. Box 1911, Chelan, WA 98816.
   b. The Scholarship committee will screen and review all applications and make selections.The committee reserves the right to reject any or all applications based on qualifications, purpose or availability of scholarship funds. Partial scholarships may be given. Applicants may re-apply for scholarships at appropriate intervals.
   c. 3) The Scholarship committee, upon selection of recipients, will authorize the Foundation office to write a check for the dollar amount of the scholarship to be applied in the manner approved. Scholarship funds will be sent directly to the appropriate school or course unless otherwise approved by the committee.
   d. 4) Scholarship awardees will be notified of acceptance in writing. If the scholarship applicant does not attend the school/course named in the application, funds must be returned to the Foundation.

SCHOLARSHIP COMMITTEE
P. O. BOX 1911; CHELAN, WA 98816
Ph. (509) 682-6125, email: foundation@LCHealthWellness.com

CONTINUING HEALTHCARE EDUCATION

Thank you for your interest in the Harold and Edna Bragg Scholarship Fund, which is administered by the Lake Chelan Health & Wellness Hospital Foundation scholarship committee. Scholarships are awarded on a "funds available" policy for education in a healthcare field.

This application is to be used for continuing education workshops, seminars, programs and special courses. **Ask for the standard application if you are applying for college credit classes.**

Please use the checklist provided to assure your application is complete before being submitted to the committee.

NAME____ DATE______________

____1. APPLICATION COMPLETE and LEGIBLE
____2. WORKING OR LIVING IN LAKE CHELAN VALLEY
____3. CERTIFIED COURSE
____4. DESCRIPTION OF COURSE WITH COST BREAKDOWN ENCLOSED
____5. CURRENT LETTER OF RECOMMENDATION FROM SUPERVISOR OR OTHER APPROPRIATE PERSON (Signed & dated)
____6. COPY OF REGISTRATION FORM WITH MAILING ADDRESS

Received at Lake Chelan Health & Wellness Foundation office:

By____ Date_______________

Recipients will be chosen on merit, need, qualifications and goals upon application.

CONTINUING HEALTHCARE EDUCATION SCHOLARSHIP APPLICATION

(Please print or type and sign application.)

NAME____ SS #____________________________

ADDRESS: (Complete Mailing, including ZIP code)____

____

EMAIL ADDRESS:____

HOME PH.____________________ WORK PH.____________ CELL PHONE_________________

LENGTH OF RESIDENCE/WORK IN LAKE CHELAN AREA? ____________________________

COURSE/PROGRAM YOU PLAN TO TAKE (**NO Acronyms, please**)___________________________

____

ADMINISTERED BY: (Attach copy of registration form with mailing address)___________________

____

DATE & LOCATION OF COURSE/PROGRAM____

C.E. CREDITS:______________ Deadline for registration_________________________________

TRAINING/COURSE EXPENSES:

Registration for Program/Course $_________ Are any meals included?___________________

Cost of Books $____________ Other fees $___________________________

Other (describe) ____

HAVE YOU RECEIVED A BRAGG SCHOLARSHIP PREVIOUSLY?__________ YEAR?____________

EDUCATIONAL BACKGROUND:

School location dates field of study/degree GPA

____

____

____

EMPLOYMENT HISTORY: (Most current first)

Employer Address Responsibilities dates

____

____

CURRENT EMPLOYER NAME, ADDRESS & PHONE NUMBER:___________________________
____

FULL TIME_________PART TIME_________CONTRACT________

IS THIS COURSE REQUIRED BY EMPLOYER ______yes _____no
IS COURSE REQUIRED FOR CERTIFICATION IN YOUR CURRENT JOB _____yes _____no

WHY ARE YOU APPLYING FOR THESE FUNDS?____
____
____
____
____

EXPLAIN YOUR CAREER GOALS AND HOW THIS COURSE/PROGRAM WILL BENEFIT HEALTH CARE:
____
____
____
____
____

ARE YOU AVAILABLE FOR A PERSONAL INTERVIEW? YES________NO__________

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT. I UNDERSTAND THIS APPLICATION WILL NOT BE CONSIDERED FOR REVIEW UNLESS IT IS COMPLETE, SIGNED AND DATED. I ALSO UNDERSTAND THAT NO MATERIALS WILL BE RETURNED.

SIGNATURE____**DATE**______________

If scholarship is approved, check is to be payable to Administrator of class ____, or Lake Chelan Community Hospital & Clinics____or other:________________________________(please specify)

(If asking for personal reimbursement, attach receipt of payment.)

Please submit application with all required documents to:

Lake Chelan Health & Wellness Foundation Scholarship Committee,

P. O. Box 1911, Chelan, WA 98816