



**ELIGIBILITY:**

**To be considered for an Indiana Health Care Foundation Scholarship, the applicant must:**

- Possess a High School diploma or higher and a minimum of 18 years of age
- Possess an active U.S. unrestricted license in one of the following professions: LPN/LVN, RN, NP, OT/PT/PTA, MD/DO/DPM/PA
- Agree to attend the ONLINE Wound Management Certification Course provided by the Wound Care Education Institute. Scholarship recipients must enroll no later than December 31, 2020 and complete the online course within 180 days. View course details at [www.wcei.net/courses/skin-wound-management/online-course](http://www.wcei.net/courses/skin-wound-management/online-course).
- Agree to complete the National Alliance of Wound Care and Ostomy (NAWCO) exam. Exam cost is covered by this scholarship.
- Demonstrate a passion to work with the elderly and/or disabled populations, as evidenced by work history and application essay.
- Return completed application with college transcripts, three letters of recommendation, and an essay to IHCF by the **October 2, 2020** deadline.
- Agree to Zoom/phone interview if and when requested by IHCF.

**Supplemental Application Materials:**

- Transcripts should be included to verify education indicated on the application.
- Essay should include, but not be limited to, your passion, experience, desire for the certification, the impact this certification will have in your healthcare career goals, reason for wanting/needing the scholarship, and why you deserve to receive it.
- Professional letters of recommendation should include at least one from a direct supervisor.
- Provide proof of active U.S. unrestricted license in one of the qualifying areas.

**Individuals related to a member of the IHCF Board of Directors are ineligible.**

**IMPORTANT NOTICE:**

**IHCF requires the following information to be submitted via the online application portal with the completed application by October 2, 2020. Failure to provide all requested information will result in disqualification.**

- ✓ Three Professional Letters of Recommendation (one from a direct supervisor)
- ✓ Essay (as described above)
- ✓ A clear photocopy of college transcripts. Transcripts do not have to be official.
- ✓ Proof of active U.S. unrestricted license in one of the qualifying areas.

**Late submissions will be not accepted.**

Application forms are available on the IHCF's website at:  
<https://www.ihca.org/workforce-scholarships/>

**Completed applications and supplemental information should be submitted online at by October 2, 2020.**

**Completed applications and supplemental information should be submitted online at:  
<https://ihcaincal.users.membersuite.com/home> and click "Engagement Hub".**

**Questions? Contact Emily Berger, IHCF Executive Director at [foundation@ihca.org](mailto:foundation@ihca.org) or  
317-616-9036.**

Indiana Health Care Foundation  
**2020 Wound Management Certification Scholarship**  
**Application**

*Individual education scholarships will be awarded based upon the information provided by the applicant. Applicants must possess a minimum high school diploma or its equivalent and have a current license(s) in one of the approved areas. Scholarship recipients will be contacted on or before November 30.*

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**Applicant Information (Please type or print in ink)**

Name: \_\_\_\_\_  
   (Last)  (First)  (Initial)

Permanent address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

By checking the following, I verify that I am at least 18 years old.

Daytime Phone: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Evening Phone: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Email: \_\_\_\_\_

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**Academic Information**

What is your highest level of degree complete? \_\_\_\_\_

High School Attended: \_\_\_\_\_

City, State: \_\_\_\_\_

Graduation Date: (mm/yy) \_\_\_\_\_

College Attended: \_\_\_\_\_

City, State: \_\_\_\_\_

Dates Attended: (mm/yy) \_\_\_\_\_ 2/yr Degree Earned: (y/n) \_\_\_\_ 4/yr Degree Earned: (y/n) \_\_\_\_

**PROFESSIONAL LICENSES:** (Check all that apply)

- LPN / LVN     RN     NP / APN     OT  
 PTA     PT     PA     MD / DO / DPM

License Number(s): \_\_\_\_\_

Issuing State: \_\_\_\_\_ **ORIGINAL** Issue Date: \_\_\_\_\_ Expiration Date: (mm/dd/yyyy): \_\_\_\_\_

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**Special Training/Awards/Volunteer Work (additional pages accepted)**

List any special training and volunteer experience in your community.

\_\_\_\_\_

\_\_\_\_\_

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**Complete Employment History (additional pages accepted)**

**Current Employer:** \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ / \_\_\_\_\_ Fax: \_\_\_\_\_ / \_\_\_\_\_

Present Position: \_\_\_\_\_ Date Started: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_

Will your employer allow you time off to attend the Wound Management Certification course?

Yes \_\_\_\_\_ No \_\_\_\_\_

Does your employer offer tuition assistance? Yes..... No.....

**Previous Employer:** \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ / \_\_\_\_\_ Date Started: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date Ended: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Position or Job Held: \_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_

**Previous Employer:** \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ / \_\_\_\_\_ Date Started: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date Ended: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Position or Job Held: \_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_  
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**Essay Questions**

On a separate page, please write an essay that covers each of the following points. Your essay should be typed. Please limit your response to 1000 words.

- Describe your work and healthcare experience, include volunteer experience in your community
- Describe your interest in working with the elderly and chronically ill and long-term care
- Describe your expectations and vision as a wound-certified professional in a residential or long-term care facility

Finalists may be asked to schedule a 30-minute phone interview with the IHCF Scholarship Committee at the discretion of the committee.  
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References: (please list the three professional references whose letters of recommendation are attached)

Reference 1 – Current Employment:

NAME: \_\_\_\_\_

FACILITY: \_\_\_\_\_

Reference 2:

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

RELATIONSHIP TO CANDIDATE: \_\_\_\_\_

Reference 3:

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

RELATIONSHIP TO CANDIDATE: \_\_\_\_\_

**Please ask references to submit to you a letter of reference to be attached to your application.** The letter should be on the individual's company letterhead if appropriate and should describe why you would be a worthy recipient of a IHCF scholarship, addressing such areas as level of maturity, sensitivity to people's needs, a known commitment to the elderly or to long-term care, that reflects good customer service and clinical skills.

**Supervisor Approval:** If you will be attending this course while employed at your current or future employer, you must include the signature of your supervisor/facility administrator. If you will not be attending the course while employed, or there is an extenuating circumstance for the committee to be aware of, please note that below and further explain in your essay.

Supervisor/Facility Administrator's Name: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Extenuating Circumstance: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Completed applications and supplemental information should be submitted online by October 2, 2020 at <https://ihcaincal.users.membersuite.com/home> and click Engagement Hub > Senior Living Awards and IHCF Scholarships > View Open Competitions and select the appropriate scholarship from the list.**

Questions? Contact Emily Berger, IHCF Executive Director at [foundation@ihca.org](mailto:foundation@ihca.org) or 317-616-9036.