

**Wound, Ostomy, Continence Nurses Society, Hawaii Affiliate  
Scholarship Application**

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

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

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

Phone: Home \_\_\_\_\_ Business: \_\_\_\_\_

U.S. Citizen:  Yes  No

**Purpose of Scholarship (*check one of the following*):**

WOC Education Program

• Name of Program: \_\_\_\_\_

• Date of Program: \_\_\_\_\_

• Content (*check all that apply*):

- Wound
- Ostomy
- Continence
- Professional Practice

Advanced Education

Name of University/College you are currently enrolled at:

\_\_\_\_\_

Nursing Degree sought (*check one of the following*):

- Master's
- Doctorate
- Post Master's Certificate

**Professional Work Credentials/Experience**

Most Recent

Employer: \_\_\_\_\_  
Name City/State Dates

Position Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employer: \_\_\_\_\_  
Name City/State Dates

Position Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Educational Background**

\_\_\_\_\_  
Institution City/State Date Graduated Degree

\_\_\_\_\_  
Institution City/State Date Graduated Degree

\_\_\_\_\_  
Institution City/State Date Graduated Degree

\_\_\_\_\_  
Institution City/State Date Graduated Degree

\_\_\_\_\_  
Institution City/State Date Graduated Degree

**Financial Information**

- 1. What is your total annual net household income (take-home pay)? \$ \_\_\_\_\_
- 2. What is your contribution to the household income? \$ \_\_\_\_\_
- 3. How many dependents did you claim on your most recent Federal Tax Form 1040? \$ \_\_\_\_\_
- 4. Will you lose income while completing your education?  
 Yes       No      Amount \$ \_\_\_\_\_
- 5. Have you applied for any other scholarships or financial assistance?  
 Yes       No      Amount \$ \_\_\_\_\_

If yes, please specify source of award and amount of scholarship:

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- 6. How are you planning to pay for your education?

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# AGREEMENT FORM

## Consent for Name Release

The WOCN, Hawaii Affiliate may use your name during the scholarship application process. Examples of this may include contacting the Director of the WOC Nursing Education Program to which you have applied; sharing your application with other Scholarship Committee members for review; and checking references to determine your eligibility. All information will be kept confidential.

I, \_\_\_\_\_, hereby give permission for the release of my name and address to determine my scholarship eligibility during the review process and, in the event that I am awarded a scholarship my name may be printed in the *Journal of WOCN*, *WOCNews*, and/or in a press release.

I understand that scholarship monies will be awarded upon proof of successful completion of the WOC Education Program or completed semester (Advanced Degree). I also understand that active membership in the WOCN Society, Hawaii Affiliate is highly encouraged.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date