**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Trinity Hospital Auxiliary Education Fund***

***Application for Educational Assistance***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last name, first Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Degree

\_\_\_\_\_\_\_\_\_\_ ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MCHD Department Supervisor’s name

Do you plan to work full time at MCHD for the next year? Yes  No 

Number of hours worked past month @ MCHD \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Course Title / Description Dates: from / to

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Course Location CEUs which apply to your license

*Please ask your supervisor to approve of this course and sign this application.*

I approve of the above employee attending the course below. Yes  No 

* This course will help my employee maintain professional skills.
* This course will allow the hospital to offer new services.
* This course will help my employee advance in their career.

Supervisor’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_

What amount are you requesting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The committee will consider lodging and travel expenses for exceptional courses that are deemed to be beneficial to MCHD’s educational and staffing goals.

Are you applying for travel expenses? No  Yes 

Round Trip Auto Mileage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lowest Airfare \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you applying for lodging expenses? No  Yes 

No. of nights \_\_\_\_\_\_\_\_\_\_\_

Have you applied for Auxiliary Education Funds previously? No  Yes 

Have you previously been awarded Auxiliary Education funds? No Yes 

Total amount of previous grants awarded $

Briefly describe your career goals:

How will this course help you achieve your goals?

How will this course benefit the mission of MCHD to provide health care to Trinity County?

Is there anything else you would like the committee to consider for your application?

I hereby agree to abide by the decision of the Trinity Hospital Auxiliary Education Committee regarding this application for educational assistance reimbursement.

I agree to provide the committee with copies of any receipts for expenses reimbursed.

I hereby give permission for the committee to give public notice of any grants awarded to me.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*For Committee Use Only*

Date received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Approved by: Trinity Hospital Auxiliary**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date of committee meeting \_\_\_\_\_\_\_\_\_\_\_\_\_ Amount approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Priority Assigned \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_