



Mailing Address: P.O. Box 1459, Tallahassee, Florida 32302-1459
Phone: (850) 224-3907 • Main Fax: (850) 681-2075 • Upstairs Fax : (850) 224-9155
Visit our web site at www.fhca.org

Bruce Taylor Scholarship Checklist

Use this list to ensure that the application is complete.

- completed application
- three completed recommendation forms (forms included in application)
- one written recommendation letter from administrator
- essay attached (see application for more details)
- copy of acceptance letter into your program of study
- receipts showing your expenses for tuition and books for current program of study
- documentation giving the complete cost of your program of study (copy of a flier or brochure)
- a statement from you declaring whether or not you receive educational reimbursement from your employer or a loan from the educational institution you attend
- estimated date of program start and finish

When you have checked off the items listed, please return the checklist along with your application and supporting documents to:

Scholarship Program
Florida Health Care Association
P.O. Box 1459
Tallahassee, FL 32302-1459

Thank you for your interest in this scholarship program.

Instructions for Applying for the Bruce Taylor Scholarship

1. Eligibility requirements.

- Have you worked at your current facility for at least six (6) months, and have you been accepted into an accredited program which would enhance your career in long term care?
- Is your facility a Florida Health Care Association member?
- Do you understand the post-graduation employment requirement?

2. Please type or print in ink. Make sure *all* blanks are filled in. Incomplete applications cannot be evaluated. Be sure to sign the applicant's contract page and get a witness' signature (anyone except the applicant can sign as a witness).

3. Ask three (3) people to complete the three required recommendation forms. The recommendation must be made by your immediate supervisor and other department managers.

4. Inform your Administrator that you are applying for this scholarship and ask him/her if he will write a letter of reference on your behalf. Such a letter is required to be considered for this scholarship.

5. At a minimum, **you should send a copy of your school's acceptance letter** along with your application. **However, no scholarship funds will be issued until we receive proof of enrollment from you.** You should send a copy of your registration slip, showing the classes for which you have actually enrolled, as soon as possible.

Also include:

- Cost of your academic program
- Receipts showing expenses (tuition, books)

6. Mail (or have your administrator mail) your application forms to:

Florida Health Care Association
P.O. Box 1459
Tallahassee, FL 32302-1459

7. Keep us informed of any changes in your employment or address.

Scholarship applications are scored and evaluated three times yearly following these deadlines:

April 30, August 30, and November 30.

You will be notified whether or not you will be awarded a scholarship. If your application is approved, a scholarship check will be sent to your Administrator, who will then present the check to you. Names of scholarship recipients will be published in FHCA's newsletter, the *Pulse*.



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Bruce Taylor Scholarship Application

Eligibility Requirements

To be eligible to apply for the Bruce Taylor Scholarship, the applicant must:

1. Be employed in a FHCA member facility with a length of employment of at least six (6) months, and
2. Be currently accepted in an accredited school to become a LPN, RN, or ARNP, and
3. Be willing to pledge that, upon successful completion of all coursework and licensure as a LPN, RN, or ARNP, he or she will work as such in a FHCA member facility for at least one year.

Name: _____
Last First Middle

Home Phone (include area code): _____

Home Address: _____
Street City State Zip

Employed by: _____

Employer Address: _____
Street City State Zip

Employer Phone Number (include area code): _____

Current Position: _____ Full Time Part Time

How long have you held this position? _____

Administrator's Name: _____

Recent Employment History

Facility Name: _____ City: _____

Position: _____ Length of Employment: _____

Facility Name: _____ City: _____

Position: _____ Length of Employment: _____

Street Address: 307 West Park Avenue, Tallahassee, Florida 32301-1427

Education	Name/City/State	Highest Grade Completed	Graduate? Yes or No	Degree	Major
High School					
College					
Other (Specify)					

Please answer the following questions:

1. Have you applied to an accredited school? Yes No

Course of Study: _____ Starting Date: _____

2. Are you (only check one): Accepted* Enrolled in classes

**If you are accepted, you may go ahead and apply for the scholarship if you submit a copy of your acceptance letter. However, you will still need to submit proof of enrollment in classes before you can receive any scholarship funds. An acceptance letter that simply gives the date you are to report for registration is not considered proof of enrollment. Also, be sure to submit the cost of the program as well as any receipts showing what expenses you have incurred.*

3. Will you continue to work during school? Yes No

School Name: _____

Address: _____

4: Will you attend school: Full Time Part Time

On a separate sheet, please write a short essay describing your:

- Educational Goals
- Career Goals: Short-term and Long-term
 - include why a career change is important to you at this time
- Long term Care History
 - include your long term care education and/or work experience
- Other licenses or certifications held or currently active

Applicant's Contract

If awarded a Bruce Taylor Scholarship, I pledge to practice as a LPN, RN, or ARNP in a FHCA member facility for at least one year after completion of my training and licensure.

I do understand that if I terminate my employment at this facility, I shall have a period of six (6) months in order to continue my employment at another FHCA member facility. The stipulated period of employment may be satisfied by the combined periods of employment at this facility or any other FHCA member nursing home or assisted living facility.

Should I fail to obtain employment after termination at this facility within the six (6) month period, the full scholarship amount, along with interest charges (at the rate of 3% per annum from the date the scholarship money was released) will be due and payable within sixty (60) days.

Applicant's Name (printed): _____

Applicant's Signature: _____ Date: _____

Current Certification or License Number, if applicable: _____

Social Security Number: _____

Witness Signature: _____ Date: _____

***Make sure ALL blanks are filled.** Send this original form along with the rest of the required application forms to:

Florida Health Care Association
P.O. Box 1459
Tallahassee, FL 32302-1459

