**VHCF PSYCH NP SCHOLARSHIP PROGRAM**

707 East Main Street, Suite 1350 • Richmond, VA 23219 • **www.vhcf.org**  
Phone: (804) 828-5804 • Fax: (804) 828-4370 • email: [info@vhcf.org](mailto:info@vhcf.org)



**Verification of Volunteer Commitment**

(*Applicant must include this completed form with his/her application packet)*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(name of applicant)* *(name of organization)*

to provide the volunteer information requested by the Virginia Health Care Foundation.

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Signature of Scholarship Applicant Date

The individual above has applied to the Virginia Health Care Foundation (*VHCF*) for a Psych NP Scholarship. This underwrites tuition and fees for attendance at a post-masters certificate program in Psych-Mental Health for eligible nurse practitioners. VHCF requires verification of volunteer commitment in a health safety net clinic. A minimum of eight hours per month is required. An indication of your intent or desire to employ the individual in a PMHNP role post-program completion is requested if applicable. Thank you.

Executive Director Name:

Name of Organization:

Address:

Emails:

Phone Number: Fax Number:

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Start Date as Volunteer: Number of Hours worked/Month:

Please indicate whether you intend to employ the individual in a PMHNP role after completion of the educational program. If you do, also indicate the number of hours/week anticipated in that role.

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**Executive Director’s Signature Date**