**VHCF PYSCHIATRIC NP (*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

**Verification of Volunteer Engagement or**

**Employment in the Health Safety Net**

(*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.

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

Signature of Scholarship Applicant Date

The individual above has applied to the Virginia Health Care Foundation (*VHCF*) for a Psychiatric Nurse Practitioner Scholarship. This underwrites tuition and all required fees for attendance at a post-masters certificate program for eligible nurse practitioners. Priority will be given to individuals working or volunteering in health safety net settings. 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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Applicant’s Volunteer Position (*if applicable)*:

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Applicant’s Employment (*if applicable)*:

Start Date as Volunteer: Number of Hours worked per week:

Position:

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

**Executive Director’s Signature Date**