**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](mailto:info@vhcf.org)



**Employer Accommodation Form**

(*Please send with the application packet)*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize my employer to provide the employment 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 Psychiatric Nurse Practitioner Program, which underwrites tuition and all required fees for attendance at a post-masters certificate program in Psych-Mental Health for licensed nurse practitioners. VHCF requires verification of employment and an indication that necessary accommodations that will be made to allow the applicant to fulfill the classroom and clinical requirements of the educational program. Thank you.

Supervisor’s Name:

Place of Employment:

Employer’s Address:

Emails:

Phone Number:

Fax Number:

Applicant’s Position:

Start Date of Employment:

Number of Hours/Month:

Current Salary (annual):

Please describe the accommodations that you will make in the applicant’s work schedule or percent of effort during the educational program:

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**Employer’s Signature Date**