Bursary Application

Applicant Information

Full Name: _____ Date of Birth: _____
Last *First*

Current Medical Position: _____
Position title *Place of work*

Address: _____
Street Address *City* *Province* *Postal Code*

Phone: _____ Email _____

Course name applied for: _____

Course Cost and Start date: _____

Have you previously applied for a VCHWF Bursary? YES ☐ NO ☐

Have you previously been awarded a VCHWF Bursary? YES ☐ NO ☐ If yes, when? _____

Education

Post-secondary: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Other: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Supervisor Recommendation

Please have your supervisor sign and give a short recommendation.

Supervisor Job Title: _____ Name: _____

Recommendation: _____

_____

_____

Supervisor : Signature: _____

I hereby affirm that all information contained in this application is true and can be verified upon request.
I have attached a short write-up on the benefits to my career and community on taking this course, which may be used for promotion for VCHWF in the future.

Applicant Signature: _____ Date: _____