

Syringa Hospital & Clinics Tuition Assistance Program Application

Last Name: _____ First Name: _____

Position/Job Title

_____ Full Time SGH Employee Describe your work at SHC _____

_____ Part Time SGH Employee Describe your work at SHC _____

_____ Not Currently Employed by Syringa Hospital & Clinics

Home Address

Street _____ City _____

State _____ Zip _____ Telephone: _____

Email : _____

Name of School You Plan to Attend: _____

School Address: _____

Expected Graduation Date: _____ Expected Program Cost : \$ _____

Amount you are requesting: \$ _____ Date Needed: _____

Check One

_____ Degree Program Specify Time for Degree Completion: _____ months/years

_____ Certification Program Specify Time for Degree Completion: _____ months/ years

_____ Non- Degree Program Specify Time for Completion _____ months/years

Course Title/Description and Number of Credits	Associated Costs
	\$
	\$
	\$
Description of Other Course-Related Expenses	
	\$
	\$

	\$
	\$
	\$
	\$
	\$
Total Funding Amount Requested on This Application	\$

Attachments:

1. Briefly explain your educational goal and its benefit to Syringa Hospital & Clinics.
2. Include any information relating to what you have accomplished working toward your goal.
3. Attach your CV, letters of recommendation, and a history of your community involvement.
4. Back-up documentation including proof of enrollment, proof of costs associated with funding request and previous term's grades.

I hereby confirm that the stated information is correct.

Signature of Applicant: _____ Date: _____

Please send completed application to: SHC Tuition Assistance, Laurie Rockwell, 607 West Main Street, Grangeville, Idaho 83530

Contact Laurie Rockwell, Syringa Hospital Foundation Director Telephone (208)507-0439 or email lrockwell@syringahospital.org for more information or with questions.