| LogoFINAL2tm Wichita Medical Research & Education foundation 3306 E Central, Wichita, Ks 67208 316-686-7172 316-687-0033 (fax)**Application for Continuing Education Funding****Please submit electronically to****scholarship@wichitamedicalresearch.org** |
| --- |
| Applicant Information |
| Last Name: First Name: |
| Day Phone: | Cell Phone: |  |
| Current address: |
| City: | State: | ZIP Code: |
| Are you a past awardee and this is a new address? | □ Yes □ No |  |
| Previous address: |
| City: | State: | ZIP Code: |
| Employment Information |
| Current employer: Department: |
| Employer address: |  |
| City: | State: |  |
| Position or Job Title:  |
| Conference Name |
| #CEUs to be awarded |  |
| Conference Location – City |  | Conference Date: |
| Conference Registration Fee:Estimated Travel Expenses: Meals/Food Funding from other sources:Airfare/Mileage Other Describe:Hotel Total Request:  |
| Email Address: |  |
| Professional Category: □ Nurse: □ Therapist □ Pharmacist □ Other  |
| Specify if other: |
| A scanned or electronic copy of the brochure must accompany this application |
| Certification and Degree Classes are Not Eligible for Funding. |
| Please describe the impact on direct patient care you expect to derive from this conference: |
| How do you plan to disseminate the new information or skills learned during this training: |
| Signature of Applicant | Date |
| Printed Name of Supervisor - Required | Phone: Email  |
| Signature of Supervisor: Date: |
| I have attached: □Copy of the Conference Brochure □ Supervisor’s Signature and email |
| For Office use only – Please do not write in this space |
| □ WMREF Ancillary □Zona Richardson □Education Fund # □ Other |
| Date Received EGC Approval Board Approval Letter Ck# |