FSJ HOSPITAL FOUNDATION

Education Grant

COMPLETE THIS FORM

NAME: ______________________ **DATE:** ______________________

ADDRESS: ____

CITY: ______________________ **POSTAL CODE:** ______________

CELL PHONE: __________________ **WORK & LOCAL:** ______________

EMAIL: ____

Name of Course: ____

Description: ____

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Start Date: ______________________ **End Date:** ______________________

Tuition/Registration ______________

Course Material ______________

Accommodations ______________

Transportation ______________

Other ______________

Total ______________

I understand that proof of payment and course completion are required prior to being eligible to receive the Education Grant. I will be held responsible to reimburse the Foundation for the financial assistance I receive, on a pro-rated basis, if I do not remain employed by the Fort St. John Hospital for a minimum of one year after completing this program.

Signature of Applicant: ______________________ **Date:** ______________________

DEPARTMENT HEAD COMMENTS:

Please comment on the relevance of the course content to the benefit of the Hospital or Peace Villa.

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Signature of Department Head: ______________________ **Date:** ______________________

Phone: ______________________

FSJHF Office Use Only:

- Current Membership
- Receipts for Program/Courses
- Grades
- Meets Program Length
- Proof of Employment

80% of Total Costs ______________

Attachments

All Receipts

Final Grades