**Long Term Care Facility Scholarship Program-**

**Nurse Employer Support Form (CNA, LPN, RN)**

**Employer:** *Please return completed form to the applicant.*

**Applicant:** Upload the completed and signed form with your application

Applicant’s Name:

Applicant’s Position/Title: l

Employer Name:

Employer Address:

Street:

City: State: Zip Code:

CEO/Executive Director Name:

CEO/ED Email:

CEO/ED Phone Number:

Place of Business Address (*if different from Employer Address*):

Street:

City: State Zip Code:

Supervisor Name and Title:

Supervisor Email Address:

Supervisor Phone Number:

Employment Start Date (*Current Employee or Offer Accepted with a Signed Employment Contract*):

Anticipated Start Date (*Employment Offer and Contract Pending*):

Current Number of Work Hours/Month:

Current Annual Salary:

Is the applicant currently in good standing at your organization?

Yes

No

N/A (*Prospective Employee/Employment Offer Pending*)

Do you commit to employing the Long-Term Care Facility Scholarship Program recipient for the required service period (*one-year for full-time employees*), provided the recipient remains in good standing?

Yes

No

Not sure

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**CEO/Executive Director or Designee Signature Date**

All questions regarding Long-Term Care Facility Scholarship Program should be directed to Olivette Burroughs at [olivette.burroughs@vdh.virginia.gov](mailto:olivette.burroughs@vdh.virginia.gov) or 804-864-7431.