VDH-OHE-MARY MARSHALL NURSING SCHOLARSHIP PROGRAM APPLICATION-CERTIFIED NURSES ASSISTANCE (MMNSP-CNA)

VERIFICATION OF CERTIFICATION

The applicant must upload the final document at the time of application.

Section 1: Applicant- **To be completed by the applicant**

I,__________________ authorize my Employer/School to provide the affiliation facility information requested by the Virginia Department of Health, Office of Health Equity (VDH, OHE.)

Signature of the Scholarship Recipient Social Security Number Date

Graduation Date/Anticipated Name of Scholarship Home Address Email & Telephone Number

Employer or School: ____________________

Address: ____________________

Phone Number: ____________________

Employer or School Contact & Email: ____________________

Section 2: Completion & Licensure **To be completed by the Applicant **Only if** the Applicant has completed & obtained licensure **

I, ____________________ as an applicant of the Mary Marshall Nursing Scholarship Program, I certify that I have completed and passed all the required examinations (practical and written) and have attached proof. If pending, please upload proof within two month of licensure.

Section 3: Employer **To be completed by Applicant's employer **Only if** employed/Anticipated employment is secured **

Employment Start Date: ________ **Employment End Date** ☐ N/A - In School

Employment Anticipated Start Date and End Date (*if enrolled or attending school*)**:** ______ ______

☐ I do not have an anticipated employer

Section 4: School ** To be completed by the Applicant's school **Only if** the applicant is enrolled or attending school. **

School Name: **School Start Date:** **Graduation Date/Anticipated**

Section 5: Employer or School **To be completed and signed by the School or Employer (whomever completed section 3 or 4) **

I attest that the above listed applicant is affiliated with ________________________ Employer/School and the applicant has completed or agreed to complete the CNA program and/or has served or agree to serve a one-year obligation with the above name Employer. *Proof of obligation will be requested every six month. In the event that the applicant is no longer employed with the employing facility for the applicant's full one-year obligation, or if the applicant is not able to complete the CNA program, please contact VDH.*

Name of Certifying Official/Administrator Title

Signature of Certifying Official/Administrator Date