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: I

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

____ __________________________

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

All questions regarding Long-Term Care Facility Scholarship Program should be directed to incentiveprograms@vdh.virginia.gov