Bellin Health Nursing Educational Funds Application

Select which Fund(s) you are applying for:

☐ **Alan F. and Ruth C. Wentworth Educational Fund –** Made possible through the generosity of Dr. Alan and the late Ruth Wentworth, intended to support continuing education of health professionals who work at Bellin Health. Funds are granted to employees who wish to continue medical education, conferences and/or seminars that enhance skills directly related to cardiac care and/or cardiac rehabilitation.

- *Academic degree programs are not eligible*
- *Maximum grant shall be $1,000.00*
- *Programs occurring from January 1 to December 31 will be considered*

☐ **Dr. Howard J. Palay Continuing Education Scholarship Fund –** Made possible through the generosity of the late Dr. Howard J. Palay, intended to support employees of the Bellin Heart & Vascular Center who wish to continue medical education, conferences and/or seminars that enhance skills directly related to the practice of Cardiology.

- *Maximum grant shall be $1,000.00*
- *Programs occurring from January 1 to December 31 will be considered*

☐ **Schwiesow Cardiac Nursing Education Fund** – Made possible through the generosity of Karl and Barbara Schwiesow, intended to support nurses who care for cardiac emergency, rehabilitation and inpatients at Bellin Health who wish to continue their medical education that enhance skills directly related to the care of cardiac patients.

- *Programs occurring from January 1 to December 31 will be considered*

Signature______________________________________ Date______________________________________

Personal Information

Full Name____

Address____

Phone____________________ Email____________________

Employment Information

Length of Employment with Bellin Health________________________

Full-time or Part-time________________________________

Current Position____________________ Department______________

Supervisor Name____________________________________

Supervisor Signature (to verify satisfactory work record) ____________________

Description of Eligible Program

Name of Program____________________________________

Date(s) of Program___________________________________

Anticipated Expenses: Registration______________

Travel________________

Lodging________________

Other________________

TOTAL________________

Do you anticipate receiving other financial assistance for this program? Yes No
If yes, describe: ____________________________________

Describe the potential individual benefit and the benefit to patients, the hospital and the community. (Attach page if necessary)

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Submit by Interoffice mail to: Steve Maricque, President, Bellin Health Foundation or by mail to: Bellin Health Foundation, 744 S. Webster Ave. Green Bay, WI 54301