The Southeast Georgia Health System/MOAA Scholarship for Clinical Education

The Southeast Georgia Health System/MOAA Scholarship for Clinical Education was established April 23, 2012 through a partnership between the Southeast Georgia Health System and the Military Officers Association of America (MOAA) to provide educational assistance for veterans and children of military families who attend the College of Coastal Georgia. It is based on one of the Association’s founding principles that “education is the cornerstone of a strong Democracy.”

This scholarship is awarded annually to outstanding students who are veterans or dependents of military families who will be attending College of Coastal Georgia to complete their degree. The award in the amount of $2,000 annually is dispersed equally at the beginning of the fall and spring semesters. Pending funding annually, a student may be eligible for up to four years of scholarship support as determined by the selection committee; provided, however, that all eligibility requirements are met and a new application is submitted for each year.

The deadline for completing this application is July 17, 2015. These applications are to be submitted back to the College of Coastal Georgia’s Office of Financial Aid. The Office of Financial Aid will deliver the applications to Southeast Georgia Health System for the scholarship committee to select a recipient.
Military Officers Association of America (MOAA) Scholarship
Recipient Agreement

_________________________________________  ______________________________________
Name                                                                                   Date

I hereby acknowledge and accept that the MOAA Scholarship is provided to me by Southeast
Georgia Health System (SGHS) to pursue the degree and/or certification in
_________________________________________ and the stipulations attached to the financial support provided.

Those stipulations are as follows:

For the financial assistance provided to me ($2,000.00), I agree to complete the year of study for
which I received scholarship funds or to repay the monies granted.

In addition, I understand that I will be required to pay any attorney fees and potential interest
expenses necessary to recover funds due SGHS.

I understand that receipt of the scholarship does not obligate nor guarantee me employment with
the Health System.

_________________________________________  ______________________________________
Signature of Student                                                                 Date

_________________________________________  ______________________________________
Human Resources Representative                                                             Date
Southeast Georgia Health System
Application for Scholarship

Name: ___________________________ SSN: ___________________________

Address: ___________________________ ___________________________
Street or F.O. Box City State Zip

Contact Numbers:

Home Phone: ___________________________ Work Phone: ___________________________
Cell Phone: ___________________________

Are you a current Southeast Georgia Health System team member?  □ Yes / □ No

Campus:

Educational Program Information

Field / Program of Study: ___________________________ School / Institution: ___________________________

Start Date: ___________________________ Projected Completion Date: ___________________________

Licensure/Certification Desired: ___________________________ Projected Exam Date: ___________________________

Educational History

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<tr>
<th>School/Institution</th>
<th>Location</th>
<th>Years Attended</th>
<th>Degree/Diploma Attained</th>
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Are you currently receiving financial assistance from Southeast Georgia Health System for other educational programs? ___________________________

Are you currently receiving or do you have approval to receive other forms of financial assistance for your desired program of study? ___________________________

If so, what type of financial assistance are you receiving or will you receive? ___________________________

Have you been convicted of a felony or have criminal proceedings against you for any reason?  □ Yes □ No

If yes, what type? ___________________________ When? ___________________________

Do you currently have criminal proceedings against you for any reason? ___________________________

Please ensure that the following documentation is completed and attached to this application:

☐ Current official transcripts
☐ 500-600 word typed essay on why you should be awarded the scholarship
☐ Three (3) letters of reference

I attest that the preceding information is true and accurate. I also acknowledge and understand that if information provided above is found to be false, the application for scholarship will be disqualified by Southeast Georgia Health System.

Signature ___________________________________________ Date ___________________________
SOUTHEAST GEORGIA HEALTH SYSTEM
Application Form for Criminal Background Check (CBC)
All requested information in Sections I and II must be legibly completed

SECTION I – Personal Information

DATE:

NAME: ____________________________

MAIDEN NAME: __________________

STREET ADDRESS: ____________________________________________________________

CITY: ___________________ STATE: _______ ZIP: _______ COUNTY: ______________

DOB: ___________________ SS#: ___________ RACE: ____________________

SEX: M F

(Drive License #: ___________________ STATE ISSUED: __________________)

(List the county and state of your most recent previous places of residence and employment)

County & State Length of Time (Years & Months)

1. ____________________________________

2. ____________________________________

3. ____________________________________

SECTION II - Authorization and Release

I hereby give permission to Southeast Georgia Health System and its agent to verify the information submitted by me and to obtain a criminal history. Neither the Health System nor its’ agent shall be violating my right to privacy in any manner and I release them from all liability whatsoever for actions related to the background investigation. I authorize release of this information to the appropriate representative(s) of Southeast Georgia Health System.

AFFILIATION NAME: _______________________________________________________

(NAME OF HOSPITAL DEPARTMENT, COMPANY, ORGANIZATION, AGENCY, CONTRACTOR, VENDOR,
SERVICE PROVIDER, EDUCATIONAL INSTITUTION/ORGANIZATION, OTHER ENTITY, ETC...)

SIGNATURE: ____________________________ DATE: ____________________________

SECTION III - Safety & Security/Police Department Use Only

☐ State Criminal Check: ____________________________ ☐ County (Name & State):

☐ Other Check: ____________________________ ☐ Phone Results:

☐ Fax Results: ____________________________ Results Entered in Database By: _______ Date: _______

Terminal Agency Coordinator/Operator: ____________________________ Date: _______

☐ Note additional information on reverse side

SGHS Safety & Security 2008

HR USE ONLY: ☐ AT ☐ BH ☐ CM ☐ MR ☐ RS ☐ SW ☐ SZ ☐ TT ☐ TW ☐ OTHER