United Ostomy Association, Inc.

ARCHIE VINITSKY SCHOLARSHIP FUND for WOC (ET) NURSING
APPLICATION FORM

(Use Typewriter or Print Legibly With Black Ink)

1. Name of Applicant: _____

   Address: _____

   City: _____ _____State/Prov.: _____Zip: _____

   Telephone: Home: _____ Work: _____

   E-mail: _____

   Social Security #: _____

2. Present Employer: _____

   Address: _____

   Present Position: _____ How Long? _____

   Full Time: _____ Part Time: _____ Hours worked per week: _____

3. Previous Employer(s) to cover last 5 years: _____
   _____
   _____
   _____
   _____
   _____
   _____

4. Schools Attended:
   School of Nursing: _____ Date: _____

   Location:_____ Degree: _____

   College/University:_____ Date: _____

   Location:_____ Degree: _____

   Post Graduate: _____ Date: _____

   Location:_____ Degree: _____

   RN Registrations, State/Province: _____ Date: _____

5. Previous work experience in the field of Ostomy Care:
   (Include Location, Position, and Length of Time).

   _____
   _____
   _____
   _____
   _____

6. Application Requirements: applications accepted at any time during the year but must be received by UOA 60 days prior to start of program.

   - Applications may be submitted before acceptance. However, proof of acceptance by a WOCN, CAET, or WCET (Foreign) accredited Wound, Ostomy, and Continence Nursing Education Program. No scholarships will be awarded retroactively; i.e. after the education program has started or is completed. (Send a copy of acceptance letter to UO when you receive it.)

   Name of School Where Applying: _____

   Anticipated dated of class: _____

   - Letter of Recommendation:

     1. If hospital employed, letters form the Director of Nursing at the hospital or Supervisor and Two Physicians (preferably with whom you have worked) must accompany this application. These letters should state the conditions of your position following the completion of the program, as well as a statement regarding your nursing practice, personality, character, etc.
     2. If other than hospital employed, letters from your Employer or Immediate Supervisor, and Two Physicians, same as above.
     3. Letter from a practicing WOC (ET) in your area, if there is one.

7. Please include an estimated budget for your education in WOC (ET) nursing:

   Tuition: _____ Supplies: _____
   Travel: _____ Other:_____
   Room: _____ _____
   Board: _____ _____

   Total Expenses: _____

   Sources of Funding:
   Amount Employer will fund, salary, etc.: _____
   Explain:_____

_____

_____

Other sources of funding and amount: _____

TOTAL EXPENCES:_____

8. Name and address of employer after completing educational program: _____

_____

_____

Estimate how many colostomies, ileostomies, and urinary diversions have been performed in your sponsoring institution within the last year. This may be obtained from Medical Records Department. If unavailable, give number of patients within your employment area and total population.

Colostomies:_____ Ileostomies: _____ Urinary Diversions: _____

Other complex wounds, pressure ulcers, tube management patients, etc.: _____

_____

Number of WOC (ET) nurses currently in your hospital, clinic, home health agency or other practice setting: _____

Total Population of area served:_____

Number of WOC (ET) nurses currently in this area: _____

Comments: _____

_____

_____

_____

_____

9. Write a brief statement describing why you are seeking education in WOC (ET) Nursing and how you plan to utilize the experience in the future. _____

_____

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10. You must be a dues-paying member of the UOA chapter and include a letter of endorsement by the Board or Executive Committee of the UOA chapter in your area. The chapter should specify that you are a dues-paying member, when you joined, and amount of your involvement. If there is not a chapter in your area, you must be endorsed by the UOA Chapter Coordinator or Area Service Director serving your area.

Name of Chapter: _____ Date Joined: _____

Describe Chapter Involvement: _____
_____
_____
_____
_____

Attach letter of endorsement form your chapter, a UOA Chapter Coordinator or Area Service Director. (Information on the UOA Chapter Coordinators or Area Service Directors may be obtained from the UOA office in Irvine, CA).

11. Give a brief statement that you will continue to be a member of the local UOA chapter and will utilize the Chapter's Visiting Program. If there is not a chapter in your area, you will help organize one and be involved as described when the chapter is organized: _____
_____
_____
_____
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_____
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12. Give a description of your view of the WOC (ET) nurse's role in Ostomy Rehabilitation and its relationship to the UOA chapter: _____
_____
_____
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_____

AGREEMENT

I understand and agree that if I receive an Archie Vinitsky Scholarship Fund Award for WOC (ET) Nursing and I do not complete the educational program identified within the body of this scholarship application, that I will return the entire amount of the fund received to the United Ostomy Association, Inc. and I will sign a letter to that effect.

I agree to submit proof of WOC (ET) nursing education program completion. (A copy of completion certificate or a letter from Program Director is acceptable).

I agree that upon completion of the program identified with this scholarship, to participate in such follow-up surveys six months after completion of training, in the evaluation of the United Ostomy Association's scholarship program.

I agree to cooperate fully with the local United Ostomy Association chapter in its ostomy rehabilitation program.

I hereby verify that the information on this application is correct and accurate and I confirm my intention to use the education made possible by the scholarship I receive in my work as a WOC (ET) nurse.

_____
Signature of Applicant

_____
Date

Mail completed application and supporting letters to:

Jean A. Smith, Director of Program Services
United Ostomy Association, Inc.
19772 MacArthur Blvd., Suite 200
Irvine, California 92612
949-660-8624 • FAX 949-660-9262