INTEGRIS
Clinical Education and Professional Development

# INTEGRIS HEALTH CAREERS
# EDUCATION ASSISTANCE APPLICATION

**CHECKLIST – Before submitting your application, please be sure that you have completed and included the following:**

- ❑ Application form
- ❑ Verification of enrollment from college admission office - **Example:** Class schedule listing classes and course code for upcoming semester, or acceptance letter for upcoming semester. If you do not have your verification of enrollment by the application deadline, please submit separately as soon as it is available.
- ❑ Official college transcripts **from all colleges and/or universities atte**nded (High School transcript may be submitted if no prior college enrollment)
- ❑ Completed reference form from your current or recent employment supervisor (form attached). **INTEGRIS employees have reference from current director.**
- ❑ Completed reference form from a current instructor (form attached)
- ❑ Completed reference form from non-family source (form attached)
- ❑ Employment history/resume
- ❑ Statement of professional goals (1-2 pages, double-spaced)
- ❑ Signed agreement and release

**APPLICATION DEADLINES: No late applications will be accepted.**

- Spring Semester—November 1st
- Fall Semester—June 1st

**After all required information is submitted, selected applicants will be contacted within 30 working days of the application deadline to schedule a personal interview with the loan committee.**

**Please send application and all documents to:**

**Judy Blalock**
**INTEGRIS Health Careers Education Specialist**

**3400 NW Expressway**
**Building C; Suite 602**
**Oklahoma City, OK 73112**

**For questions regarding the application:**

**Tara Vogt, MS, RN, CMSRN**
**INTEGRIS Health Careers Nursing Student Advisor**
**Tara.Vogt@integrisok.com**

**Ashley Jones, MS, RN**
**INTEGRIS Health Careers Nursing Student Advisor**
**Ashley.Jones@integrisok.com**

## INTEGRIS HEALTH CAREERS EDUCATION ASSISTANCE GUIDELINES

***STUDENTS INTERESTED IN REGISTERED NURSING.***

Target Population:

- All INTEGRIS Health employees in prerequisites or professional course work for entry to practice as a registered nurse.
- Community members (non-employees) in prerequisites or professional course work for entry to practice as a registered nurse. Note: If you are an INTEGRIS registered nurse returning to school for a BSN, MSN, DNP or PhD, please complete the Nursing Academic Loan Application.

Financial Assistance: Up to a maximum of:

- Maximum of $3,000 per semester (maximum of $6,000 per year).
- Financial assistance will only be given for academic credits required by the accredited program in which the participant is currently enrolled. Participants will receive assistance for tuition, fees, and books; receipts must be provided before checks are distributed.

Work Commitment Requirements:

- 2080 hours work commitment for up to every $6,000 of financial assistance received upon completion of program and achieving licensure.

Application Requirements:

- Verification of a minimum of a 3.0 grade point average for applicants in prerequisite courses.
- Completed application form.
- Copy of class schedule or other proof of enrollment in prerequisites or professional course work for an accredited program
- Reference from the department supervisor or director if currently employed with INTEGRIS. Please return in a sealed envelope.
- Reference from most recent employment supervisor if not employed with INTEGRIS. Please return in a sealed envelope.
- Reference from a high school teacher or counselor (for recent high school graduates). Reference from college instructor (for college students). Please return in a sealed envelope.
- Personal reference from non-family sources. Please return in a sealed envelope.
- Employment history or resume.
- Statement of professional goals.
- Signed Agreement and Release.

Program Requirements:

- Participants must be enrolled in **prerequisites or professional** curriculum for an accredited Registered Nurse program.
- Participants must maintain a minimum of a 2.75 cumulative grade point average throughout the nursing program.
- Participants must show proof of payment to the academic institution in which they are enrolled at the end of each semester before additional funds are awarded.
- Participants must provide a copy of their transcript at the end of each semester before additional funds are awarded.
- INTEGRIS Employees must have at least a "Performs as Expected" Performance Appraisal and must not be under any disciplinary action upon application and throughout the academic program.
- Participants must submit a Progress Report at the midterm of each semester.
- Program participants must fulfill work commitment upon completion of education and obtaining licensure.
- If any of these requirements are not met, the participant may be placed on probation or may be terminated from the program. If termination occurs, the recipient will be required to pay back all funds awarded.

In addition to the Health Careers Education Assistance Program, INTEGRIS Health FT or RPT employees are also eligible to receive tuition reimbursement according to Policy SYS-HR-140.

# INTEGRIS Health – Metro
## HEALTH CAREERS
## EDUCATION ASSISTANCE APPLICATION

**Will you now or in the future require INTEGRIS to commence ("sponsor") an immigration case in order to employ you (for example, H-1B or other employment-based immigration case)? This is sometimes called "sponsorship" for an employment-based visa status. □ Yes □ No**

**If you answered "YES" to the previous question, you are not eligible for this program.**

**Name: _____**
**(Last) (First) (Middle Name-Please print full name)**

**Address: _____**
**(Street) (City) (State) (Zip)**

**Home Phone Number: _____Cell Number: _____**

**Email: _____Social Security #:_____Date of birth: _____**

**Please check all that are applicable and provide the requested information:**

- ❑ **INTEGRIS HEALTH EMPLOYEE Title: _____Employee ID #_____**

  **Department Name and Mailbox: _____**

  **Department Supervisor/Manager: _____**

  **Department Telephone Number: _____**

- ❑ **Related to INTEGRIS Health employee? _____NO _____YES**

  **If YES, state employee name and relation: Name:_____ Relation:_____**

- ❑ **Non-INTEGRIS Health Employee/High School Student Title: _____**

  **Current Employer: _____**

  **Employer Address: _____**

  **Supervisor Name: _____**

  **Telephone Number: _____**

- ❑ **Currently enrolled as a student: Please designate either High School or College**

  - **High School Name: _____**
    **OR**
  - **College Name: _____**
  - **Credit Hours Complete: _____**
  - **Current Cumulative GPA: _____**
  - **Expected date of Graduation: _____**

- ❑ **How did you hear about the INTEGRIS Health Careers Education Assistance Program?**
  - ❑ **Career Fair**
  - ❑ **School Visit**
  - ❑ **Recruitment Event**
  - ❑ **Friend/Classmate: Please provide name:_____**
  - ❑ **Other: _____**

# INTEGRIS Health – Metro
## HEALTH CAREERS EDUCATION ASSISTANCE APPLICATION

**Please complete the following as thoroughly as possible as this information will be taken into consideration in the selection process.**

**Are you currently receiving financial assistance or scholarships for your education?**

- ❑ **YES – If so, please list program/source (s): _____**
- ❑ **NO**

**ACTIVITIES:**
**Please list school, professional, organizational activities/teams or volunteer services in which you have participated within the last 2 years. (Example: Volunteer work, community service projects, church activities, school activities/clubs, etc.) Please include dates.**

1. _____
2. _____
3. _____
4. _____
5. _____

**STATEMENT OF PROFESSIONAL GOALS: Please include your professional goals for at least the first three years after your college graduation, how you wish to accomplish these goals as an INTEGRIS Employee, and why you chose this profession. (Double Space – please limit to no more than 2 typewritten pages)**

**REFERENCES: Please list the names, address and telephone numbers of your three references. Please be sure that one of them is your Employer Supervisor/Manager or an Instructor at your High School or College:**

1. _____
   **Name** **Telephone Number**
   _____
   **Address**
2. _____
   **Name** **Telephone Number**
   _____
   **Address**
3. _____
   **Name** **Telephone Number**
   _____
   **Address**

**Please include the completed Personal Reference forms from each of your references (in a sealed envelope) with your application.**

## INTEGRIS Health - Metro

### HEALTH CAREER EDUCATION ASSISTANCE APPLICATION

**EMPLOYMENT HISTORY: Your professional resume or curriculum vitae may be used in place of this form. List your three most recent jobs with your most recent/current job first. Please indicate if you were employed under a different name.**

1. **Employment Dates:** _____ **Title:** _____

   **Company Name:** _____

   **Supervisor Name:** _____

   **Address:** _____

   **Telephone Number:** _____

   **Reason for leaving:** _____

2. **Employment Dates:** _____ **Title:** _____

   **Company Name:** _____

   **Supervisor Name:** _____

   **Address:** _____

   **Telephone Number:** _____

   **Reason for leaving:** _____

3. **Employment Dates:** _____ **Title:** _____

   **Company Name:** _____

   **Supervisor Name:** _____

   **Address:** _____

   **Telephone Number:** _____

   **Reason for leaving:** _____

# INTEGRIS Health – Metro

## HEALTH CAREERS EDUCATION ASSISTANCE APPLICATION

**AGREEMENT AND RELEASE:**

**I _____, have read the Education Assistance Guidelines and understand the terms and conditions for receipt of financial assistance. I agree to execute all necessary written agreements and releases in the event that I am offered and accept financial assistance from INTEGRIS Health.**

**I understand that submission of this application in no way guarantees financial assistance or a guarantee of employment by INTEGRIS Health or any of its subsidiaries (collectively referred to herein as "INTEGRIS Health").**

**I certify that the information on this application is accurate and complete without omission. I understand that the Education Assistance Committee of INTEGRIS Health, retains sole discretion on who shall be offered assistance and shall not be liable in any respect if financial assistance is not granted to me or if granted, is withdrawn for any reason including but not limited to false statements, answers, or omissions made by me in this application.**

**I hereby authorize the release of the Education Assistance Committee of any information regarding my educational history, grades, degree, work history, or personal characteristics by my current employer, schools, and persons listed to submit a personal reference and hereby knowingly and voluntarily release said employers, schools, or persons from all liability or damage which may result from the release of this information.**

**I hereby knowingly and voluntarily release INTEGRIS Health, the Education Assistance Committee, and all officers, directors, employees, agents or members of any such entities, from any and all liability or damage which may result from the use of this information for any purpose related to this application, any financial assistance I may subsequently receive or my employment with INTEGRIS Health.**

_____ _____

**DATE** **SIGNATURE**

_____

**PLEASE PRINT OR TYPE NAME**

## HEALTH CAREERS EDUCATION ASSISTANCE APPLICATION
## PERSONAL REFERENCE FORM

**My acquaintance with (name of applicant) _____has been as:**

- ❑ **Employer Supervisor/Manager/Director**
- ❑ **School Advisor**
- ❑ **Instructor/Teacher**
- ❑ **Physician**
- ❑ **Professional Colleague**
- ❑ **Friend**
- ❑ **Other: _____**

**How long have you known this applicant? _____**

**Rating of applicant: Check the column of the term that is applicable.**
**Please place the completed form in a sealed envelope to be returned to the applicant or you may fax it to (405)951-9737.**

- ❑ **INTEGRIS Directors/Supervisors: As the applicant's Supervisor/Director, I declare that he/she is currently in good standing and has not had any disciplinary action within the last 12 months at INTEGRIS.**

| | Outstanding | Above Average | Average | Below Average | Do not Know |
|---|---|---|---|---|---|
| **Common sense and judgment** | | | | | |
| **Concern for others** | | | | | |
| **Cooperation with others** | | | | | |
| **Initiative** | | | | | |
| **Intelligence** | | | | | |
| **Sense of Commitment and Responsibility** | | | | | |

**What qualities or characteristics does the applicant have that you believe would contribute to his/her success as a healthcare professional?**

**What qualities or characteristics does the applicant have that you believe might interfere with his/her success as a healthcare professional?**

**In your own words, briefly describe this person, and indicate why the applicant should or should not be awarded the financial assistance for pursuing a health career education.**

**NOTE: A signature and contact information is required in order for this reference to be accepted.**

**Signature: _____ Title: _____**

**Print Name: _____ Date: _____ Daytime Phone Number: _____**

## HEALTH CAREERS EDUCATION ASSISTANCE APPLICATION
## PERSONAL REFERENCE FORM

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| **Initiative** | | | | | |
| **Intelligence** | | | | | |
| **Sense of Commitment and Responsibility** | | | | | |

**What qualities or characteristics does the applicant have that you believe would contribute to his/her success as a healthcare professional?**

**What qualities or characteristics does the applicant have that you believe might interfere with his/her success as a healthcare professional?**

**In your own words, briefly describe this person, and indicate why the applicant should or should not be awarded the financial assistance for pursuing a health career education.**

**NOTE: A signature and contact information is required in order for this reference to be accepted**

**Signature: _____ Title: _____**

**Print Name: _____ Date: _____Daytime Phone Number: _____**

**HEALTH CAREERS EDUCATION ASSISTANCE APPLICATION**
**PERSONAL REFERENCE FORM**

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| **Initiative** | | | | | |
| **Intelligence** | | | | | |
| **Sense of Commitment and Responsibility** | | | | | |

**What qualities or characteristics does the applicant have that you believe would contribute to his/her success as a healthcare professional?**

**What qualities or characteristics does the applicant have that you believe might interfere with his/her success as a healthcare professional?**

**In your own words, briefly describe this person, and indicate why the applicant should or should not be awarded the financial assistance for pursuing a health career education.**

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