**Mid-Atlantic Region WOC Nurses Society**

**Financial Sponsorship Application**

**Purpose**

Financial sponsorship funds are intended to support Wound, Ostomy and Continence nurse related trips, events and/or education (this DOES NOT include WOCN or APNP educational support; see the Scholarship Application)

Fund allocation is determined solely by the MAR Board and is based on fiscal status and other pertinent considerations.

**Eligibility Criteria**

* Active, due-paying WOCN Society member who shows support of the Society by involvement in Mid-Atlantic Region initiatives and is an active participant in his/her local Affiliate.
* The requested funds must directly focus on addressing wound, ostomy and/or continence issues or nursing practices that support the WOC mission, vision and goals.

**Application**

LEAVE NO BLANKS. Incomplete applications will not be reviewed. **Return the completed application to:** Mid-Atlantic WOC President: financial.support@marwocn.org

**Applicant Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which is your local Affiliate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Note: Prior to submitting this application, please notify your Affiliate President of your request for sponsorship. The MAR Board will be contacting your Affiliate President to confirm your active participation in your local Affiliate.

When does your WOCN membership expire (your membership must be active now and at the time of your event): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attach a brief summary of your request. Include the name of the event/trip/program, population served, dates of service and your specific role as it relates to your WOC nursing specialty.**

How much $ you requesting and what will the $ be allocated for (i.e. travel, room/board, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you requesting and/or receiving funding from any other sources? If so, from whom and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fund Agreement**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby agree to the following obligations after accepting Mid-Atlantic Region of the WOC Nurses Society funds:

* The MAR Board will decide if I will be offered monetary sponsorship before or after the trip.
* I will provide trip receipts, if requested by the MAR Board.
* I will provide a written summary of how the funds supported the WOCN mission to the MAR President within one month of completion of the sponsorship. This may be posted on the MAR website, and I may be asked to give a presentation at a MAR Regional Conference.
* In the event that I am unable to fulfill the purpose for which the monies were requested by me from the Mid-Atlantic Region of the WOC Nurses Society, I understand that all monies will be forfeited and returned to the Mid-Atlantic Treasurer in full within 15 days of the recipient’s decision to withdraw from trip/event or he purpose of requested funds no longer falls within the scope of WOC practice.

Print Name/Credentials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*NOTE: Keep a copy of your completed application for your own records.*