

**OHIO ASSOCIATION FOR HEALTHCARE QUALITY
SCHOLARSHIP APPLICATION FORM**

Name of Applicant: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Educational Background: _____

CPHQ? Yes No Previous Recipient? Yes No Year? _____

Other Certifications: _____

Years of experience in Health Care Review/ Coordination of Care? _____

OAHQ Membership District: 1 2 3 4

Indicate appropriate category:

_____ Published Article (Copy or verification attached)

_____ Poster Session/Paper Presentation (brief description and verification attached)

_____ Educational materials (Copies attached)

_____ Oral Presentation (Verification attached)

I am aware that my name as a Scholarship Recipient and my type of achievement will be published in the OAHQ Quarterly Newsletter.

(Date)

(Signature)

OAHQ would like to notify your organization of your award. If this is acceptable, please provide:

Place of employment: _____

Address: _____

Management Contact Name/Title: _____

Mail Scholarship Form to: **Ohio Association for Healthcare Quality
Program Team Chairperson
P.O. Box 461045
Cleveland, OH 44146-1045**