

Name of the institution you plan to attend:

Name of the course you plan to take (please include course description):

What is the tuition fee for this course (HST Included)?

\$ _____

What are the textbook/materials cost for this course?

\$ _____

Semester for which you seek funding (Please check one):

Fall _____ Winter _____ Spring/Summer _____ Year 20 _____

Course registration deadline: _____

Do you have access to another source of funding to take this course?

Yes No

If yes, please give details about the type of funding, and indicate if awarded:

Have you ever received Moving Lives Forward funding? _____

For Office Use Only - Reference #: _____

If yes, please indicate when you received funding:

PLEASE ATTACH PROOF OF COURSE COMPLETION/TRANSCRIPT

(Only applies to applicants who previously received a Moving Lives Forward Scholarship)

Please write a few sentences to state how this bursary will benefit you and indicate your personal development goals and/or your career goals.

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Would you be willing to provide a brief testimonial about how this bursary has benefited you, upon completion of your course?

Would you fill out a survey regarding your experience?

Are you or your family a member of NAPE?

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Section B: Reference Form

Note: This section is to be completed by a mental health and addictions clinician, who has had a therapeutic relationships with the applicant. The clinician will send the completed application form (Sections A and B) directly to the Health Care Foundation office at the address listed on the following page. All information will be kept confidential.

Name (of staff member): _____

First Name

Last Name

Place of work:

Work telephone number:

Email address: _____

Professional relationship to the applicant: _____

To the best of your knowledge, does the applicant require this financial assistance to pursue their education?

To your knowledge, has the applicant received any source of other funding to take this course?

If yes, the source of funding is: _____

For Office Use Only - Reference #: _____

In your professional opinion, how would the applicant benefit from this request?

**Would you recommend the applicant to the Scholarship Committee for funding?
Please elaborate:**

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For Office Use Only - Reference #: _____

Signature

Date

**If you require additional information or applications, please call 709-777-5901.
Please forward this application (Section A & B) to:**

Email: hcf@healthcarefoundation.ca

**Mail: Moving Lives Forward Fund
c/o Health Care Foundation
71 Goldstone Street, Suite 103
St. John's, NL A1B 5C3**

***For Office Use Only - Reference #:* _____**

The Moving Lives Forward Scholarship Program is proudly funded by NAPE.