STANFORD HOSPITAL & CLINICS
Stanford University Medical Center

# Transformation Scholarship Application

HR | Business Center
1530 Page Mill Rd
Palo Alto, CA 94304-5513
www.HR4Uonline.org
(650) 723-HR4U (3-4748)
(650) 618-2551 (e-Fax)

**PERSONAL DATA**

Name _____ Home Telephone (_____) _____

Address _____ Social Security Number _____

City, State, Zip _____

**EDUCATIONAL BACKGROUND**

| | School Name & Address | Dates Attended | Course of Study/Major | List Diploma or Degree |
|---|---|---|---|---|
| High | | | | |
| College | | | | |
| College | | | | |

**STANFORD HOSPITAL AND CLINICS WORK HISTORY** ☐ SHC ☐ Shared Services

Date of Employment _____ Current Job Title _____

Department _____ Supervisor _____

Telephone _____

**TRANSFORMATION SCHOLARSHIP APPLICATION**

Program of Study _____

Post-Secondary Institution _____

Address _____ Telephone Number (_____) _____

Are you currently enrolled in this program? ☐ Yes ☐ No
*If **YES***, when did you begin the program? _____ Length of program _____
What is your anticipated completion date? _____
*If **NO***, Anticipated start date? _____ Length of program _____
What is your anticipated completion date? _____

What is the start date for your program in the upcoming quarter or semester? _____

What is the estimated total cost of tuition, fees, and books for one semester? _____

Have you been formally accepted into the program of study by the post-secondary institution indicated above? ☐ Yes ☐ No
*If **YES***, please attach the letter of acceptance with this application.
*If **NO***, when do you anticipate a formal decision regarding the acceptance of your admission application? _____

The purpose of my educational plan is to:

☐ Enhance skills in my current position
☐ Prepare for a new job role

## ESSAY

Please describe how you have contributed to the delivery of patient-centered care at Stanford Hospital and Clinics. In addition, describe your *specific* career goals and how they support the mission of SHC. Please limit your response to no more than two typewritten pages.

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## TO BE COMPLETED BY THE EMPLOYEE'S SUPERVISOR

- Has the employee been employed by SHC or Shared Services a minimum of 18 months? ☐ **Yes** ☐ **No**
- What is the date of the employee's most current appraisal? _____
- What is the employee's current appraisal rating? ☐ **Exceeds** ☐ **Meets Plus** ☐ **Other:** please explain. (A rating of Exceeds or Meets Plus is required for Program participation.) _____
- Has the employee worked at an FTE commitment of at least .5 for the last 18 months? ☐ **Yes** ☐ **No**
- Will the employee continue to work at least a .5 FTE commitment during program participation? ☐ **Yes** ☐ **No**
- If the employee has (or will have) less than a .5 FTE commitment, please explain. (A commitment of .5 of greater is required for program participation.) _____

## ACKNOWLEDGMENT OF LIMITATIONS AND AGREEMENT TO APPLICATION TERMS

I have carefully reviewed the criteria set forth in the Guidelines for the Stanford Hospital and Clinics Transformation Scholarship Award, and more fully detailed in the Transformation Scholarship Program Policy. I understand that I am required to work a minimum of two years for Stanford Hospital and Clinics, Shared Services, or Lucile Packard Children's Hospital upon completion of my scholarship program. I also understand that I may not seek full time employment with another organization while benefiting from this scholarship award. I acknowledge and agree that I will be required to reimburse SHC for any program monies received if I violate these employment requirements. However, in the event I am terminated involuntarily while benefiting from this scholarship award, I will not be required to reimburse SHC.

I understand that I may request reimbursement for learning expense from other Education Assistance programs that SHC offers, for which I am qualified during my participation in the Transformation Scholarship Program, as long as they are separate and distinct expenses that will not be reimbursed through the Transformation Scholarship Program.

I also understand that it is my responsibility to identify and pay any applicable income taxes that are required as a result of receipt of this benefit.

Receipt of the Transformation Scholarship program benefit does not guarantee future employment at SHC or LPCH in my current or a different job. SHC reserves the right to award or deny employee participation in the program, and can elect to discontinue the program at any time.

Employee's Signature _____ Date _____

Employee Name (Please Print) _____ Employee No or Soc Sec No _____

Supervisor Review Signature _____ Date _____

Director or VP Review Signature _____ Date _____

## FOR HUMAN RESOURCE OFFICE USE ONLY

| *Scholarship Application Packet* | *Date Received* | *Date Approved* | *Rating* |
|---|---|---|---|
| Scholarship Application | | | |
| Supervisor's Approval | | | |
| Director/VP Approval | | | |
| Essay | | | |
| Letter of Acceptance to designated program | | | |
| Request for Consideration form | | | |

Date employee notified _____

| *Reimbursement Tracking* | *Date Received* | *Date Approved* | |
|---|---|---|---|
| Proof of enrollment | | | |
| Evidence of payment | | | |

Calendar Year: _____ CY Limit:$_____ Amount approved for this request:$ _____

Human Resources Approval _____ Date _____

Date sent to Payroll _____