PROFESSIONAL DEVELOPMENT PROGRAM
ROCKEFELLER COLLEGE UNIVERSITY AT ALBANY State University of New York

HWRI GRANT APPLICATION

January 1, 2018 – December 31, 2018

Section 1	**Applicant Information**	**Complete all fields**

First Name: ______________________ Last Name: ______________________

Address: ______________________ Apt: ________

City: ______________________ State: ________ Zip: ________

Home Phone: (   ) ____________ Work Phone: (   ) ____________ Cell Phone: (   ) ____________

Email Address: ______________________

Preferred method of communication (check all the apply):	Email ☐	Home Phone ☐	Cell Phone ☐	Work Phone ☐

I am a **U.S. citizen**, **permanent alien** or **resident alien** authorized to work in the U.S. ☐ Yes ☐ No

I have at least one year of experience as a **permanent New York State employee.** ☐ Yes ☐ No

Section 2	**DOH Employment Information**	**Complete all fields**

Agency: ☐ OMH* ☐ DOCCS ☐ OPWDD

Facility Name: ______________________

Work Address: ______________________

Work City/State/Zip: ______________________ Work County: ______________________

Current Job Title: ______________________ Work Shift: ______________________

*OMH Employees Only: I am a participant in OMH's Nurse Development Program. ☐ Yes ☐ No

Section 3	**Nursing Program Status Information**	**Complete all fields**

Please check the degree you are pursuing/intend to pursue: ☐ RN ☐ BSN ☐ MSN

Please check your status **(choose A or B):**

A ☐ Not yet attending a college /applying to school(s) --- Anticipated Start Date: ______________

B ☐ Enrolled in a college with an accredited nursing program

If you chose B, then choose C, D or E and fill-in information to the right:

C ☐ Not yet in the nursing program (taking pre-requisite courses)

D ☐ Full time student (enrolled in a nursing program)

E ☐ Part time student (enrolled in a nursing program)

Today's Date: ______________

Number of credits:

completed: _____ in-progress: _____ still needed: _____

Anticipated Graduation Date (month/year) ______/______

Enter name of college and nursing program: ______________________

City: ______________________ State: ________ Zip: ________

This HWRI Grant is funded by the New York State Department of Health (in consultation with NYSDOL) and is administered by The Research Foundation for State University of New York, through the Professional Development Program, Rockefeller College, University at Albany

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Section 4 | **Agreement** | **Please read carefully and check each box below.**

- ☐ The information on this application is true.
- ☐ I will provide any additional documentation requested to support the information on the application.
- ☐ I intend to participate in the DOH HWRI Grant program administered by The Research Foundation for SUNY.
- ☐ I will provide the Professional Development Program with a copy of my grades for any courses paid for with HWRI grant funds, as well as nursing program or employment status information updates such as graduation date and job promotions.
- ☐ I understand that as a condition for program participation, I must maintain at least a 2.0 GPA if I am enrolled in an RN degree program or a 2.5 GPA if I am enrolled in a BSN or MSN program.
- ☐ I understand awards made through this program apply only to eligible activities completed during the period, January 1, 2018 – December 31, 2018 and funding is contingent on availability.
- ☐ I understand reimbursements paid to me by The Research Foundation for SUNY may be considered taxable income. I will follow all federal, state and local requirements regarding reporting and payment of taxes.

Your original signature indicates you have read, understood and agreed to the statements above.

Applicant's Signature: ______________________________ Date: ____________

Section 5 | **Other Required Signatures**

Educational Mentor: ______________________________ Date: ____________
Print Name Signature

Agency Representative:
(OMH or DOCCS or OPWDD) ______________________________ Date: ____________
Print Name Signature

Send your completed and signed application to:

OMH

Juanita Goyette
OMH/Office of Coordinated Nursing Services
44 Holland Avenue – 8th Floor
Albany, NY 12229
Phone - (518) 474-8501
Fax - (518) 474-6909

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OPWDD

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