KONA COMMUNITY HOSPITAL AUXILIARY

CONTINUING EDUCATION APPLICATION

Name: _____ Phone:_____

Address: _____
(Street) (City)

KCH Hire Date: _____ Current Job Title: _____

How long in your current position? Yrs. _____ Mos._____ Previous jobs or capacities at KCH? Yes _____ No _____
(If yes, please explain:)

What is the title and description of the educational training/seminar/course you plan to take? *(if available, please add brochure or other printed description to this form)*

Where is that training located? _____

What is the total cost of the training? _____ Will you be doing this training on your own time: Yes___ No ___

Proposed training start date: _____ Proposed training end date: _____

Explain the value of this class to your current or future employment at KCH or what benefit would this course have to you: *(if more space is needed, please use the back of this page)*

Have you received continuing education funds from KCH Auxiliary before? Yes _____ No _____

Supervisor's Signature: _____ Tel: _____ Date: _____

Department Head Signature: _____ Tel: _____ Date: _____

If selected to receive a stipend from the KCH Auxiliary, funds will be paid upon receipt of evidence of your course completion and grade (if applicable.)

Signed: _____ Date: _____

Return completed application to KCH Dept. of Education Supervisor

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Auxiliary Use: Date Reviewed: _____ Determination: _____ KCHA Pres: _____

Award Amount: _____ Percentage of Request: _____

Remarks: _____

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(Rev 11/10/2014)