**CERTIFICATION EXAM SCHOLARSHIP APPLICATION**

(Please print or type)

NAME:

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certification Testing Period: Fall \_\_\_\_\_\_\_\_, Spring \_\_\_\_\_\_\_\_\_, Summer \_\_\_\_\_\_\_\_\_
**\*Certification Examination must be completed within two (2) examination cycles after receipt of funds. If not completed within two (2) cycles, applicant must return the funds to the Treasure of the State Organization.**

INSTITUTION OR STUDY GROUP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AMOUNT OF REQUEST: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(requested amount must not be more than NAMSS established application fees – please refer to NAMSS website @ [www.namss.org](http://www.namss.org))

Yes No

|  |  |  |
| --- | --- | --- |
|  |  | I am currently employed as a medical staff services professional. If yes, number of years: \_\_\_\_ |
|  |  | I am a member in good standing of the Washington Association Medical Staff Services. |
|  |  | I have not been awarded a WAMSS Scholarship fund within the last 3 years.  |
|  |  | I am currently CPMSM certified |
|  |  | I am currently CPCS certified |
|  |  | I am currently a WAMSS officer/Board member/chapter officer/appointed and/or paid official of the WAMSS organization. |

Please attach a personal, 500 words or less, typewritten statement about past, present, and planned contributions to the medical staff services profession with a brief review of how participation in the planned activity will be of benefit to you as the applicant both professionally and personally.

By my signature, I hereby request consideration of my application for scholarship funds offered by WAMSS. I enclose the requested supporting documentation to assist the Scholarship Committee in arriving at a recommendation. I attest that the information submitted within this application is true and accurate. I further understand that false representation or misstatements may cause denial of my application.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mail the completed form to:

WAMSS Scholarship Committee Chair:

Aviana Jupiter, CPCS

Email: wamssscholarship@gmail.com

For the applicant’s reference, NAMSS Eligibility Requirements noted below:

Candidates must meet ONE of the following eligibility routes at the time of application. The CCN reserves the right to conduct random audits to verify candidate eligibility.

CPCS Examination:

1. At the time of application, candidate must be currently employed in the medical services profession for at least the past 12

consecutive months and have a total of three years of experience within the past five years, OR

2. Be a CPMSM in good standing and be employed for at least the past 12 consecutive months in the medical services profession.

CPMSM Examination:

1. At the time of application, candidate must be currently employed in the medical services profession for at least the past 12

consecutive months and have a total of five years of experience within the past eight years, OR

2. Be a CPCS in good standing and be employed for at least the past 12 consecutive months in the medical services profession.