**CERTIFICATION EXAM SCHOLARSHIP APPLICATION**

(Please print or type)

NAME:

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

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

Certification Testing Period: Fall \_\_\_\_\_\_\_ (year), Spring \_\_\_\_\_\_\_\_\_(year), Summer \_\_\_\_\_\_\_\_\_(year)
If selected to receive funds, WAMSS Treasurer will arrange to pay funds directly to NAMSS on behalf of Scholarship Recipient.

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

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

(requested amount must not [exceed](http://exceed) $400)

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. Please also attach a current copy of your resume.

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:

Email: **scholarshipchair@wamss.org**

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 12

consecutive months in the last 24 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 12

consecutive months in the last 24 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.