

NEW JERSEY HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION MEMBER'S ANNUAL SCHOLARSHIP APPLICATION

MEMBER INFORMATION

Member Name _____
Member Address _____

Membership # _____

Years in HFMA _____ # Years in NJ Chapter _____

Member Employer _____

APPLICANT INFORMATION PART 1 - PERSONAL DATA

Applicant Name _____
Address _____

Relationship to Member _____
College _____

Course (s) to be taken _____

Matriculated Student YES _____ NO _____
Degree/Program Pursued _____
Anticipated Graduation Date _____
Major _____ Annual Tuition _____
Amount of Employer Support _____
Amount of Other Scholarships Awarded _____

(Documentation must be provided supporting tuition
and/or books, employer's reimbursement policy
and enrollment in school.)
(Please label as Attachment D.)

SIGNATURE _____ DATE _____

Please return completed package no later than
March 1, 2026 to:

Maria Faccipot at NJHFMA@aol.com or mail to:
Chair Scholarship Committee, NJHFMA
Healthcare Financial Mgmt. Assoc. - NJ Chapter
PO Box 6422
Bridgewater, NJ 08807