



**WOCNCB Benevolence Fund**

**Criteria**

- Currently certified through the WOCNCB in wound, ostomy, continence, or foot care.
- Demonstrate financial hardship that prevents recertification in a specialty/specialties.
- All requested information is completed in its entirety.

**Application**

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Certification number: \_\_\_\_\_

Date certification expires: \_\_\_\_\_

Annual gross household income (includes all sources) \$ \_\_\_\_\_/per year

[Include a copy of the most recent Federal Income Tax Return.]

Number of individuals living in the household: \_\_\_\_\_

Describe the circumstances that led to the hardship: \_\_\_\_\_

Include a written reference that can confirm the hardship. \_\_\_\_\_

Amount of funding being requested: \$ \_\_\_\_\_

Employment History – *list last five positions and employers:*

POSITION	EMPLOYER

I declare that this application and all supporting documentation fully qualifies me for funding by the WOCNCB.

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