

IOWA HEALTH INFORMATION MANAGEMENT ASSOCIATION

INSTRUCTIONS FOR THE COMPLETION OF THE IaHIMA SCHOLARSHIP APPLICATION

APPLICATION FORM:

This form should be completed in detail and must be typed or printed.

AHIMA MEMBERSHIP CARD:

A copy of your card showing Component State Association must be included with your application.

EDUCATIONAL ENROLLMENT AND ELIGIBILITY VERIFICATION:

This verification is to be completed by the Director of the program in which you are currently enrolled.

RECOMMENDATION FORMS:

Please submit two completed Recommendation forms with the application. One recommendation must be from the Program Director or an Instructor in your program if you are a Coding Certificate or RHIT student. If you are an RHIA student, one recommendation must be from your Academic Counselor (College Level) and/or Program Director.

Other recommendations may be from previous instructors, employers, practicum supervisors, or other professional contacts. These individuals should be knowledgeable of your character and ability.

TRANSCRIPTS:

Submit official transcript(s), which include all credits earned.

PROFESSIONAL GOALS:

Include with your application an essay that describes your future goals as a health information management practitioner and include at least the following:

1. Why did you choose this career?
2. What do you think this profession can do for you?
3. What contributions do you feel you can make?
4. Why do you feel you deserve scholarship consideration?

PLEASE SUBMIT THE ABOVE MATERIALS TO THE CHAIRPERSON OF THE SCHOLARSHIP COMMITTEE NO LATER THAN February 15, 2010.

**CHAIRPERSON: Kathy O'Toole, RHIT
Buena Vista Regional Medical Center
PO Box 309
Storm Lake, Iowa 50588**

IOWA HEALTH INFORMATION MANAGEMENT ASSOCIATION

SCHOLARSHIP APPLICATION

Instructions: **Please print or type when completing this application.**

NOTE: All records of applicant will remain confidential and will be used only for the scholarship review and determination of applicant's qualification.

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I. PERSONAL INFORMATION:

Name: _____

Home Address: _____ **City/State/Zip:** _____

Home Phone Number: _____ **Cell Phone Number:** _____

Name of School/Program: _____

Address: _____ **City/State/Zip:** _____

AHIMA Number: _____

II. PROFESSIONAL/BUSINESS EXPERIENCE: Please describe your employment history below including date of employment, employer, position held, and a brief description of your duties, or you may submit a recent resume.

III. EDUCATIONAL HISTORY: Please describe below all postsecondary schools attended and degrees pursued and/or achieved. Please note, you may omit if included on your resume.

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IV. OTHER AFFILIATIONS AND AWARDS: Please describe below any memberships you hold in professional organizations as well as awards and honors received.

Signature of Applicant

Date

IOWA HEALTH INFORMATION MANAGEMENT ASSOCIATION

**SCHOLARSHIP APPLICANT EDUCATIONAL ENROLLMENT AND
ELIGIBILITY VERIFICATION**

This is to certify that _____ is currently enrolled in the
(student name)
Health Information Management Program or a student in the graduate program at

(Name/address, city/zip of education institution)

and that by May 2010, he/she will be in the last year of the program (**for Associate Degree or last half of program for RHIA---does not apply to graduate student or coding certificate applicants**).

(Signature of Program Director/Department Chairperson) (Date)

INSTRUCTIONS:

Applicant

After entering your name in the space provided, forward this form to the Director of the Health Information Management Program, Department Chairperson, or Independent Study Program as appropriate for the program in which you are currently enrolled.

Program Director/Chairperson

This student has applied for a scholarship from the Iowa Health Information Management Association. For the application process to be complete, this form must be signed by you and returned to the Scholarship Committee chairperson at the address below, no later than February 15, 2010.

Return Form To:

**Kathy O’Toole
Buena Vista Regional Medical Center
PO Box 309
Storm Lake, Iowa 50588
712-213-8687**

Please note: Application Verification and Reference Letter may be returned in the same envelope if completed by the same person.

IaHIMA SCHOLARSHIP APPLICANT REFERENCE FORM

Instructions to Applicant

This form is to be given to the two persons you have selected as references (Remember, one must be from the Program Director or an instructor within your program).

Instructions to Reference

Please reply to each of the following questions as completely as possible. In answering any of the questions, if you have not been in a position to observe, please so state.

NAME OF APPLICANT _____

1. How long have you known the applicant?
2. In what capacity did you work with or were you associated with the applicant?
3. Please comment on the applicant's abilities in the following areas:

ABILITY TO ORGANIZE AND MANAGE

ABILITY TO COMMUNICATE EFFECTIVELY (written and oral communication)

INTERPERSONAL RELATIONSHIP SKILLS

JOB PERFORMANCE, STRENGTHS AND WEAKNESSES IN PERFORMING DUTIES AND RESPONSIBILITIES

4. Other Comments....

Signature of Reference: _____
 Position or Title: _____
 Address/City/State: _____

Please return by: February 15, 2009 **TO: Kathy O'Toole**
Buena Vista Regional Medical Center
PO Box 309
Storm Lake, Iowa 50588

