

NJSFWC SECOND CHANCE DOMESTIC VIOLENCE SURVIVORS AWARD

APPLICATION FORM

(ALL FIELDS ARE REQUIRED)

Name:		
Date of Birth:	Social Security #	
Mailing Address		
City	State	Zip Code
Primary Phone Number		
Secondary Phone Number		
Email		
Referral Source (How did you learn about this scholarship)		
Are you a citizen or a permanent resident of the United States? Yes No		

EDUCATION HISTORY

Name of School:	
City	State
Dates of Attendance	
Start	End
Major Subject/Course	
Degree Earned	
Date of Graduation High School or GED	
College/University/School address	

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EDUCATION GOAL

Name of School wishing to attend	
City	State
Degree/Certification sought	
Are you currently enrolled in an eligible program?	
Estimated Graduation Date:	

List classes you are intending to take in the upcoming term. Include Course Number and the Name:

Start Date: _____

Explain your educational goals and how this award will help you achieve them (you may use additional paper)

New Jersey State Federation of Women's Clubs

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Explain your career goals

Describe a challenge you have faced and the steps you took to overcome that challenge.

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AGENCY/COUNSELOR/SOCIAL WORKER RECOMMENDATION

(All Fields Required)

To the Applicant: To qualify for scholarship consideration you must identify an intimate partner abuse service provider you have worked with who is willing to attest to the services and support you have received as a survivor of intimate partner violence. Please complete this page and deliver it to your provider, along with the questionnaire. These pages must be submitted to NJSFWC along with all requested materials. The purpose of this confidential agreement is to assist NJSFWC in assessing your scholarship application. Any information shared will be treated with discretion and respect.

I hereby give permission to any duly-authorized representative of my intimate partner abuse service provider to supply information requested by GFWC pertaining to myself. I release my provider and NJSFWC of any and all liability for sharing such information. This release shall be in effect until I state, in writing, that it is no longer valid.

Signature of Candidate

Date

Candidate's Name	
Provider's Name	
Contact Person	
Mailing Address	
Email	Phone Number
Website (if applicable)	

Complete the questionnaire on the following page and return it to your applicant, along with the 'Authorization for Release of information signed by you and the applicant. Incomplete applications will not be considered.

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1. How long have you worked with this applicant?

2. What is your experience with the applicant?

3. What is your understanding of the applicant's education goals?

4. Please describe why you believe the applicant is deserving of this scholarship award. Speak to your knowledge of the applicant's motivation, capability and commitment to his/her career goals.

Name: _____

Title: _____

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Signature

Date

REFERENCES

Return this form with your application. Letters of recommendation must be included in your application. Only one of these may be a personal friend or family member. Your provider representative may be a reference. Others you may also consider asking for a reference could include an employer, teacher, and/or community leader.

Reference Number 1

Name	
Relationship to applicant	
Address:	
Phone Number	Email

Reference Number 2

Name	
Relationship to applicant	
Address:	
Phone Number	Email