

OREGON ASSOCIATION MEDICAL STAFF SERVICES

FILE: #0037
Adopted: 2/24/96

TITLE: Scholarship Policy
Revised: 3/22/07

Reviewed: 5/7/09

POLICY

OAMSS awards a scholarship annually to members who wish to obtain their certification or attend an annual OAMSS or NAMSS conference.

To qualify for the scholarship all applicants must be active OAMSS members of at least twelve (12) months, who are in good standing, and whose institution is unable/unwilling to sponsor attendance/certification.

1. Applicants must submit an OAMSS application form in writing to the Scholarship Committee or may submit an application and required materials on-line via the OAMSS website (www.oamss.com). Applications are considered complete when the Scholarship Committee has received the application and required supporting documents. (*Refer to attachments 1, 2, 3*)
2. Applicants must provide descriptive information related to the current or planned educational activity for which the scholarship is being sought, and cost of the activity. In addition, applicant must provide the Scholarship Committee proof of enrollment in the current or planned education activity at the time consistent with materials submitted with the application.
3. Applicants must include a typewritten statement detailing past, present, and planned contributions to the medical staff services profession, and include a brief explanation of how the planned activity will benefit applicant both professionally and personally
4. Application deadline is thirty (30) days prior to the applicable event.

The Scholarship Committee will evaluate applications based on the following:

- a. Commitment to educational growth as a medical staff professional;
- b. Demonstration of sincere enthusiasm and support of the goals and mission of OAMSS
- c. Future benefits to applicant and to OAMSS as a result of the scholarship

The Board of Directors shall budget a set amount each year for the OAMSS Scholarship Fund, considering funds are available in the total budget for the year. The Board of Directors has determined that Conference registration and reimbursements (lodging, transportation, and meals in accordance with the Travel Policy) will not exceed \$500.00 for State and \$1000.00 for National Conferences.

The Scholarship Chair will forward application packets by blind copy to each member of the

Scholarship Committee for evaluation and selection of the recipient(s).

The Board of Directors will choose and notify the awardee of the annual scholarship based on the Scholarship Committee's recommendation.

The Scholarship Chair will notify all applicants of the scholarship recipient(s) in writing.

Oregon Association Medical Staff Services
STATE/NATIONAL CONFERENCE SCHOLARSHIP

STATE Conference NATIONAL Conference

CRITERIA FOR ANNUAL EDUCATIONAL CONFERENCE SCHOLARSHIP

- 1) Must be an Active OAMSS member of at least twelve (12) months in good standing.
- 2) Member's institution will be contacted to confirm inability/unwillingness to sponsor attendance at both the State Annual Educational Conference and National Annual Educational Conference.
- 3) Cannot be a member of the Board of Directors for either the State or National associations.
- 4) Conference registration and reimbursements (lodging, transportation, and meals in accordance with the Travel Policy) will not exceed \$500.00 for State and \$1000.00 for National.
- 5) Application and a typewritten statement outlining the applicant's past, present and planned contributions to the Medical Staff/Credentialing profession along with a brief review of how participation in the conference will be of benefit to the applicant both professionally and personally must be submitted by the deadline.
- 6) Applicants will be measured by the degree of the following criteria:
 - Commitment toward education growth as a medical staff/credentialing services professional
 - Sincere enthusiasm and support for the goals of OAMSS
 - Future benefits to OAMSS resulting from educational assistance to the applicant

DISCLAIMER: The OAMSS Scholarship Committee reserves the right to withhold awarding a scholarship.

APPLICANT NAME: _____

SUPERVISOR NAME: _____

INSTITUTION: _____

ADDRESS: _____

PHONE: _____

FAX: _____

I have been employed for _____ months/years as a Medical Staff/Credentialing Services professional. I hereby request consideration of my application for scholarship funds offered by OAMSS. I have enclosed the requested documentation to assist the Scholarship Committee in arriving at a decision. I attest that the information provided is true and correct.

APPLICANT SIGNATURE: _____ **DATE:** _____

SUPERVISOR SIGNATURE: _____ **PHONE:** _____

Mail or FAX to: **OAMSS Scholarship Chair:**

** Application packet must be received by the Scholarship Chair no later than thirty (30) days prior to*

the applicable event. Confirmation of application receipt will be provided.

Oregon Association Medical Staff Services

CERTIFICATION EXAMINATION SCHOLARSHIP

SPRING Examination **FALL Examination**

CRITERIA FOR CPMSM/CPCS CERTIFICATION SCHOLARSHIP

- 1) Must be an Active OAMSS member of at least twelve (12) months in good standing.
- 2) Member's institution will be contacted to confirm inability/unwillingness to sponsor certification examination testing fee(s).
- 3) Cannot be a member of the Board of Directors for either the State or National associations.
- 4) Application and a typewritten statement detailing past, present, and planned contributions to the medical staff services profession, and include a brief explanation of how the planned activity will benefit applicant both professionally and personally
- 5) Applicants will be measured by the degree of the following criteria:
 - Commitment to educational growth as a medical staff professional;
 - Sincere enthusiasm and support for the goals of OAMSS;
 - Future benefits to OAMSS resulting from certification assistance

DISCLAIMER: The OAMSS Scholarship Committee reserves the right to withhold awarding a scholarship.

APPLICANT NAME: _____

SUPERVISOR NAME: _____

INSTITUTION: _____

ADDRESS: _____

PHONE: _____

FAX: _____

I have been employed for _____ months/years as a Medical Staff/Credentialing Services professional. I hereby request consideration of my application for scholarship funds offered by OAMSS. I have enclosed the requested documentation to assist the Scholarship Committee in arriving at a decision. I attest that the information provided is true and correct.

APPLICANT SIGNATURE: _____

DATE: _____

SUPERVISOR SIGNATURE: _____

PHONE: _____

Mail or FAX to: **OAMSS Scholarship Chair**

** Application packet must be received by the Scholarship Chair no later than thirty (30) days prior to registration deadline. Confirmation of application receipt will be provided.*

Oregon Association Medical Staff Services

CERTIFICATION FOR CPMSM/CPCS PREP COURSE/MATERIALS SCHOLARSHIP

- Prep Course Prep Materials

Specify Materials required and cost: _____

CRITERIA FOR CERTIFICATION PREP COURSE/MATERIALS SCHOLARSHIP

1. Must be an Active OAMSS member of at least twelve (12) months in good standing.
2. Member's institution will be contacted to confirm inability/unwillingness to sponsor attendance or purchase of prep course materials.
3. Cannot be a member of the Board of Directors for either the State or National associations.
4. Application and a typewritten statement detailing past, present, and planned contributions to the medical staff services profession, and include a brief explanation of how the planned activity will benefit applicant both professionally and personally
5. Applicants will be measured by the degree of the following criteria:
 - Commitment to educational growth as a medical staff professional;
 - Sincere enthusiasm and support for the goals of OAMSS;
 - Future benefits to OAMSS resulting from certification assistance

DISCLAIMER: The OAMSS Scholarship Committee reserves the right to withhold awarding a scholarship.

APPLICANT NAME: _____

SUPERVISOR NAME: _____

INSTITUTION: _____

ADDRESS: _____

PHONE: _____

FAX: _____

I have been employed for _____ months/years as a Medical Staff/Credentialing Services professional. I hereby request consideration of my application for scholarship funds offered by OAMSS. I have enclosed the requested documentation to assist the Scholarship Committee in arriving at a decision. I attest that the information provided is true and correct.

APPLICANT SIGNATURE: _____

DATE: _____

SUPERVISOR SIGNATURE: _____

PHONE: _____

Mail or FAX to: OAMSS Scholarship Chair

- *Application packet must be received by the Scholarship Chair no later than thirty (30) days prior to applicable event. Confirmation of application receipt will be provided.*

**OREGON ASSOCIATION MEDICAL STAFF SERVICES
VOUCHER AUTHORIZATION**

Payable to _____ _____ _____	
Amount	\$ _____
Account # _____	For:
Total \$ _____	

Requested By: _____

Signature: _____

Approved: _____

Date: _____

<i>For Treasurer's Use:</i> Date Paid: _____
Check #: _____
Amount: _____

OREGON ASSOCIATION MEDIAL STAFF SERVICES EXPENSE REIMBURSEMENT REQUEST

Name:								
Address:							Telephone:	
Event/Strategy/Date:							Location:	
							Line Item:	
Date:	Mon/	Tues/	Wed/	Thur/	Fri/	Sat/	Sun/	Total
Miles Driven								
Mileage*	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Taxi/transportation								\$0.00
Auto(tolls,parking,etc)								\$0.00
Hotel (Room & Tax Only)								\$0.00
Hotel-Other list individually only as authorized								\$0.00
Meals:	breakfast							\$0.00
	lunch							\$0.00
	dinner							\$0.00
Tips								\$0.00
Other (explain below)								\$0.00
								\$0.00
								\$0.00
								\$0.00
Honorarium								\$0.00
Totals	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

*current federal reimbursement rate

TOTAL REIMBURSABLE EXPENSE	\$	-
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Items Billed Directly to OAMSS

NOTE: Receipts are required for ALL items billed directly to OAMSS.

Month	Day	Description of Expense	Air Travel	Hotel (show room & tax & please explain other)	
			Amount	Amount	Explanation Other
TOTALS			\$0.00	\$0.00	

TOTAL OAMSS PAID EXPENSE:	\$0.00
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I certify that I am familiar with the provisions of OAMSS' Expense Statement and Travel Policy and that this expense statement is accurate as to actual and necessary business expense.

Signed: _____

Date: _____