

MICHIGAN NURSES FOUNDATION

RECOVERY SCHOLARSHIPS RESEARCH

Recovery Financial Support Application

Name _____ Registration License # _____

Address _____
Street City State Zip

Home phone (_____) _____ Cell phone (_____) _____

Personal Email _____

Employer _____ Unit _____

Last date worked _____ Est. return to work date _____

Current income: Self \$ _____/month Household \$ _____/month

Number of dependents** _____

***relatives for whom you provide more than 50% of their support.*

Treatment Facility _____ Start date _____

Treatment Provider _____

Address _____
Street City State Zip

Contact Name _____

Phone (_____) _____ Email _____

Estimated Treatment Amount \$ _____

Counseling \$ _____ Lab \$ _____ Processing \$ _____

Amount covered by insurance \$ _____

Submit completed form to contact@minursesfoundation.org

or mail to:

Michigan Nurses Foundation, 2310 Jolly Oak Road, Okemos, MI 48864