541.751.8523
kstevens@sowib.org
990 S 2nd St
Coos Bay, OR 97420

Clinical Faculty Wage Adjustment Program Application

Applicant Information

Full Name: ______________________________________ Date: ____________

Last *First* *M.I.*

Address: ______________________________________

Street Address *Apartment/Unit #*

____

City *State* *ZIP Code*

Phone: ____________________ Email ____________________

Clinical Faculty for (UCC or SOCC) ____________

Education

School where you completed your nursing program ____________________ ASN/BSN/MSN ____________

Current Healthcare Employer

Company or Institution: ______________________________ Phone: ____________

Address: ______________________________ Supervisor: ____________

Job Title: ____________________ Hourly Wage: **$** ____________

Required Documents

- W9
- Wage Stub from Healthcare Employer Showing Current Hourly Rate
- Direct Deposit Form (optional)

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to program acceptance, I understand that false or misleading information in my application or interview may result in my disqualification.

Please email completed application and required documents to kstevens@sowib.org

Signature: ______________________________ Date: ____________