

**APPLICATION**  
**RISK MANAGEMENT TRAINING SCHOLARSHIP**

*Please complete and return to:*  
*Washington Counties Risk Pool*  
*Member Services Division, Loss Control;*  
*2558 R.W. Johnson Rd. SW, Suite 106*  
*Tumwater, WA 98512-6103; OR*  
*FAX to: (360) 292-4501*

**APPLICANT COMPLETES THIS SECTION:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
(Please Print)

Dept. \_\_\_\_\_ County: \_\_\_\_\_

Telephone: \_\_\_\_\_ Mailing address: \_\_\_\_\_

FAX #: \_\_\_\_\_

Email: \_\_\_\_\_  
(City) (Zip)

1. Identify the training being applied for and location (*include a copy of brochure, if available*):

\_\_\_\_\_

2. Anticipated costs for the training: \$ \_\_\_\_\_

3. Describe the risk management element that will be addressed during this training, and how your attendance will enhance or improve your county's and/or the WCRP risk management program(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Upon completion of this training, I AGREE to share the information gained from this training with other WCRP member counties by either instructing and/or reporting at future Risk Pool training sessions or meetings.

\_\_\_\_\_  
(Signature of Applicant)

**DESIGNATED RISK MANAGER FOR WCRP COMPLETES THIS SECTION:**

Please identify what role the applicant has relative to risk management in your county, and how you see that their attendance at this training will enhance or improve the risk management program in your county and/or the Risk Pool:

\_\_\_\_\_

\_\_\_\_\_

Upon the applicant's completion of this training, I AGREE that this applicant will be made available to share the information gained from this training with other Risk Pool members counties either by instructing and/or reporting at future WCRP training sessions or meetings.

\_\_\_\_\_  
(Signature of Designated Risk Manager for WCRP)