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 with Current Hourly Rate
- SOCC/UCC Part Time Agreement or Contract
- Copy of pay stub from SOCC / UCC when received

Optional – completed ACH form for Direct Deposit

SOWIB USE ONLY

Employer Rate _____
SOCC/UCC Rate _____

Hourly Variance _____

Hours Paid _____

ADJUSTMENT _____

Approved by _____

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: _____