

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
PUBLIC HEALTH SERVICE  
INDIAN HEALTH SERVICE

FORM APPROVED:  
OMB Approval No. 0917-0006  
Exp. Date: 9/30/2007

See Estimated Average Burden Time  
per Response on Reverse Side.

**PUBLIC LAW 94-437—TITLE I SCHOLARSHIP PROGRAM  
FACULTY/EMPLOYER EVALUATION**

REGARDING	STUDENT'S NAME	SOCIAL SECURITY NUMBER
	CAREER CATEGORY	EMAIL ADDRESS

The student identified above is applying to receive an Indian Health Service (IHS) Scholarship. The information on this form is requested pursuant to Section 751-756 of the Public Health Service Act, as amended, and applicable program regulations which provide that, in evaluating and selecting individuals for scholarships, consideration will be given to faculty or employer recommendations.

The information provided on this form is treated as confidential and may only be disclosed outside the Department of Health and Human Services in accordance with provisions of the Privacy Act of 1974 (P.L. 93-579) and the terms and conditions of the applicable Privacy Act Notice published by the Department in the *Federal Register*.

PLEASE RETURN COMPLETED FORM TO APPLICANT

1. How do you rate the educational/work achievement of this applicant? *(Please provide written comments.)*

5 -  OUTSTANDING      4 -  ABOVE AVERAGE      3 -  AVERAGE      2 -  BELOW AVERAGE      0 -  POOR

2. How do you rate the applicant's relationships with other people?  
Consider such things as ability to work and get along with others. *(Please provide written comments.)*

5 -  OUTSTANDING      4 -  ABOVE AVERAGE      3 -  AVERAGE      2 -  BELOW AVERAGE      0 -  POOR

3. Based on this applicant's personal, emotional, ethical attributes, how do you rate his/her over-all potential for the practice of primary health care, especially in a health manpower shortage area?  
*(Please provide written comments.)*

5 -  OUTSTANDING      4 -  ABOVE AVERAGE      3 -  AVERAGE      2 -  BELOW AVERAGE      0 -  POOR

**Please provide written comments:**

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Type of work: \_\_\_\_\_

Length of time known: \_\_\_\_\_

**Statement of Conflict of Interest: I certify I am not related to applicant by blood or marriage.**

NAME (Print or type)	SIGNATURE	DATE
TITLE OF POSITION	PLACE OF EMPLOYMENT	

**ESTIMATED AVERAGE BURDEN TIME PER RESPONSE**

Public reporting burden for this collection of information is estimated to average 50 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: Indian Health Service, OPHS/DHPS/Scholarships Branch, 801 Thompson Avenue, TMP Suite 450, Rockville, MD 20852, ATTN: PRA (0917-0006).

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