OMB Number: 2900-XXXX
Estimated Burden: 50 minutes

Department of Veterans Affairs

Health Professional Scholarship Program (HPSP) &
Visual Impairment and Orientation and Mobility Professionals Scholarship Program (VIOMPSP)

Evaluation & Recommendation Form

Return this completed form to: **HPSP/VIOMPSP** Department of Veterans Affairs, 1250 Poydras St., Suite 1000, New Orleans, LA 70113

Scholarship Program: ☐ HPSP ☐ VIOMPSP	Applicant's Name *(Last, First, MI):*

The applicant identified above is applying to receive a Department of Veterans Affairs scholarship. The information on this form is requested pursuant to Title 38 United States Code, Sections 7501-7505, 7601-7619, and 7631-7636 as amended, and applicable program regulations. These governing documents provide that, in evaluating and selecting individuals for scholarships, consideration will be given to faculty or employer recommendations.

PRIVACY ACT NOTICE:

The VA is asking you to provide the information on this form under the authority of 38 U.S.C. 7502 and 7602 in order for VA to determine the applicant's eligibility to receive a scholarship award. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information for: civil or criminal law enforcement; congressional communications; the collection of money owed to the United States; litigation in which the United States is a party or has interest; the administration of VA training and scholarship programs, including verification of the applicant's eligibility to participate; and personnel administration. You do not have to provide this information to VA but, if you do not, VA may be unable to process the applicant's request for a scholarship. If you give VA a social security number, VA will use it to obtain information relevant to determining whether to grant a scholarship, and to administer the applicant's scholarship, if awarded. It also may be used for other purposes authorized or required by law.

Consent for Release of Information

CONSENT: I authorize the educational institution in which I am, or will be, enrolled to release to VA information regarding my enrollment status and academic standing, including grade point average, both now and while I am participating in the VA Health Professional Scholarship Program/Visual Impairment and Orientation and Mobility Professionals Scholarship Program as well as the plan of study and projected costs. I understand that this authorization is voluntary, and that I may revoke this consent at any time. However, I further understand that if I voluntarily revoke this authorization after the award of the scholarship, my scholarship award may be terminated and I may be liable for the damages in accordance with provisions of 38 U.S.C. Sections 7505 and 7617. I authorize my prior employers and other individuals who receive this form to release the requested information to the Department of Veterans Affairs.

Applicant's Signature _____ Date Signed _____

Evaluation/Recommendation Type: ☐ Academic Faculty ☐ Employer (non-VA) ☐ VA Employer ☐ Other

Relationship to applicant:	Length of time known:

EVALUATION *(Comments are strongly encouraged and will assist in the scoring of the applicant's application.)*

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 ☐ 1 - Poor

Comments:

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 ☐ 1 - Poor

Comments:

3. Based on this applicant's personal, emotional, ethical attributes, how do you rate his/her over-all potential for providing clinical services to our nation's Veteran population? *(Please provide written comments)*

☐ 5 - Outstanding ☐ 4 - Above Average ☐ 3 - Average ☐ 2 - Below Average ☐ 1 - Poor

Comments:

Scholarship Recommendation: ☐ Recommended ☐ Not Recommended

Conflict of Interest Statement: I certify that I am not related to the applicant by blood or marriage. Initials: _____

Institution/Organization *(Name & Address)*	Evaluator *(Print)* _____	Evaluator *(Signature)* _____
	Title/Position _____	Date _____