OMB Number: 2900-XXXX
Estimated Burden: 10 minutes

Department of Veterans Affairs

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

VA Scholarship Offer Response

Retain this attachment until you are notified of your selection as a scholarship recipient. Do not mail this form with your application.

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 your 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 your 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 your request for a scholarship. If you give VA your social security number, VA will use it to obtain information relevant to determining whether to grant a scholarship, and to administer your scholarship, if awarded. It also may be used for other purposes authorized or required by law.

Applicant's *(Last, First, MI):*	Social Security Number:

Please indicate whether you are accepting or declining the Department of Veterans Affairs scholarship award by checking the appropriate space below.

The scholarship award will not be issued until this form is completed and received by the scholarship program office.

Health Professional Scholarship Program (HPSP)

☐ I accept the scholarship award for the 20 __ - 20 __ school year.

☐ I decline the scholarship award for the 20 __ - 20 __ school year.

Visual Impairment and Orientation and Mobility Professionals Scholarship Program

☐ I accept the scholarship award for the 20 __ - 20 __ school year.

☐ I decline the scholarship award for the 20 __ - 20 __ school year.

A. I understand that the VA will require me to maintain enrollment, an acceptable level of academic standing, and complete all coursework in the course of study for which the scholarship award is provided. _____ Initial

B. I understand that the VA will require me to notify the scholarship program in writing, within 10 days if I change my enrollment status, plan of study, academic standing, name, mailing address, telephone number, e-mail address, or bank information. _____ Initial

C. **FOR HPSP ONLY.** I understand the required clinical tour in an assignment or location determined by VA while enrolled in the course of education for which the scholarship is provided. _____ Initial

D. I understand the required service obligation to work in a VA health care facility in a full-time position for which I will be prepared after completing the education program supported by the scholarship program. _____ Initial

E. I understand that the VA agrees to provide an appointment to a full-time position providing health services in the profession for which the scholarship is provided. _____ Initial

F. I understand that I may be subject to the penalties as described in the scholarship agreement if I do not complete the education program for which I am requesting scholarship support or if I do not complete the required service obligation. _____ Initial

I accept this scholarship award with the terms and conditions that have been explained to me, and which are included in this document.

_____ Applicant's Signature

_____ Date

☐ My address, e-mail, and phone number are the same as on my application.

☐ Please update my contact information as indicated below.

New Address *(Include Street Address, City, State, and ZIP Code):*

New E-mail:	New Phone Number:

Payment Information for the direct deposit of stipends and reimbursement of other related costs. ***Direct deposit of funds is required.***

Name of Financial Institution:	Account Number:	Routing Number:

Please indicate Account Type: ☐ Checking ☐ Savings

If you have any questions please contact the Department of Veterans Affairs, Healthcare Talent Management Office at (504) 565-4900 or HRROScholarshipTeam@va.gov

Complete this form and return immediately to:

HPSP/VIOMPSP Department of Veterans Affairs, 1250 Poydras St., Suite 1000, New Orleans, LA 70113

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