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

FORM APPROVED:
OMB Approval No. xxxx-xxxx
Exp. Date: x/xx/xxxx

See Estimated Average Burden Time per Response on Reverse Side.

PUBLIC LAW 94-437 – TITLE I SCHOLARSHIP PROGRAM

FACULTY/ADVISOR EVALUATION

RECIPIENT'S NAME	SOCIAL SECURITY NUMBER

ADDRESS	PHONE: CELL ☐ HOME ☐

CAREER CATEGORY	IHS AREA OFFICE	EMAIL ADDRESS

The student identified above is requesting a change of status related to his/her 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 individuals, consideration will be given to faculty or advisor 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 achievement of this applicant?
   5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 0 - ☐ 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.
   5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 0 - ☐ POOR

Comments:

3. Based on this applicant's personal, emotional and ethical attributes, how do you rate his/her overall potential for the practice of primary health care, especially in a Health Professional Shortage Area (HPSA)?
   5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 0 - ☐ POOR

Comments:

4. Type of work (applicant):
5. Length of time known:

Required signature on back of this form

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

I certify that the information provided in this evaluation is accurate. I understand that it may be investigated and that any willfully false representation is sufficient cause for rejection of this application.

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

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, IHS Scholarship Program, 801 Thompson Ave., TMP-450, Rockville, MD 20852.