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.

EF

## PUBLIC LAW 94-437 – TITLE I SCHOLARSHIP PROGRAM REQUEST FOR TUTORIAL ASSISTANCE

|                      | • • •         | Q0201101110      | - TOTAL ACCIONA     |            |                |                   |
|----------------------|---------------|------------------|---------------------|------------|----------------|-------------------|
| RECIPIENT'S NAME     |               |                  | SOCIAL SECURITY NUM | BER        |                |                   |
| ADDRESS              |               |                  |                     | PHONE: CEL | L D HOME D     |                   |
|                      |               |                  |                     |            |                |                   |
| CAREER CATEGORY      |               | IHS AREA OFFICE  |                     | EMAIL ADDF | RESS           |                   |
|                      |               |                  |                     |            |                |                   |
| SCHOLARSHIP PROGRA   | AM: Prepar    | atory $\square$  | Pre-Graduate        | ☐ Healt    | th Professions | ;                 |
| ENROLLMENT STATUS    | : □ Fall      | □Winter          | ☐ Spring            | □Summe     | ər             |                   |
| □ Semester           |               | ☐ Quarter        | ☐ Trimester         |            |                |                   |
|                      | ☐ Full-time   | ☐ Part-time      |                     |            |                |                   |
| I AM SEEKING TUTORIA | AL ASSISTANO  | CE FOR THE FOLL  | OWING COURSE        | S):        |                |                   |
| COURSE NUMBER        | RSE TITLE     |                  |                     |            | HRS.           |                   |
|                      |               |                  |                     |            |                |                   |
|                      |               |                  |                     |            |                |                   |
|                      |               |                  |                     |            |                |                   |
|                      |               |                  |                     |            |                |                   |
|                      |               |                  |                     |            |                |                   |
| DESCRIPTION OF ACAI  | DEMIC PROBL   | _EM(S)/JUSTIFICA | TION OF ASSISTA     | NCE:       |                |                   |
|                      |               |                  |                     |            |                |                   |
|                      |               |                  |                     |            |                |                   |
|                      |               | TUTORIA          | L REQUEST           |            |                |                   |
|                      |               | (Must incl       | ude all tutors)     |            |                |                   |
| NAME(S) OF TUTOR(S)  |               |                  |                     |            |                |                   |
|                      |               |                  |                     |            |                |                   |
|                      |               |                  |                     |            |                |                   |
|                      |               |                  |                     |            |                |                   |
| NUMBER OF HOURS RATE | ES PER HOUR S | UBTOTAL COST     | NUMBER OF           | HOURS RAT  | ES PER HOUR    | SUBTOTAL COST     |
|                      |               |                  |                     |            |                |                   |
|                      |               |                  |                     |            |                |                   |
|                      | TOTAL COST:   |                  |                     |            |                |                   |
|                      |               |                  |                     | Required   | d signature on | back of this form |

IHS-856-20

| RECIPIENT'S SIGNATURE   |   | DATE   |  |  |  |  |  |
|---|---|--------|--|--|--|--|--|
| ADVISOR'S NAME (Print)  |   | DATE   |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
| ADVISOR'S SIGNATURE   | PHONE:  |        |  |  |  |  |  |
| Return to:  IHS Scholarship Program Attn: Program Analyst 801 Thompson Ave., Suite 120 Rockville, MD 20852  Reviewed (IHS use only):  |   |        |  |  |  |  |  |
| Analyst, Branch Chief or Designee   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
|   |   |        |  |  |  |  |  |
| ESTIMATED AVERAGE BURDEN TIME PER RE  | SDONSE  |        |  |  |  |  |  |
| Public reporting burden for this collection of information is estimated to average 8 time for reviewing instructions, searching existing data sources, gathering and matcompleting and reviewing the collection of information. An agency may not condition to required to respond to, a collection of information unless it displays a current Send comments regarding this burden estimate or any other aspect of this collections for reducing this burden to Indian Health Service, IHS Scholarship TMP-450, Rockville, MD 20852. | minutes per response including aintaining the data needed, and uct or sponsor, and a person is ntly valid OMB control number ection of information, including | l<br>s |  |  |  |  |  |