

National Health Service Corps Scholarship Program

U.S. Department of Health and Human Services Health Resources and Services Administration

RECEIPT OF EXCEPTIONAL FINANCIAL NEED SCHOLARSHIP (For School Use Only – Must be Completed by Financial Aid Official)

Name of Student:	
Last 4 digits of the Student's Social Security Number:	
The Financial Aid Official identified below certifies that the above-named studer	nt
☐ has received	
\square has <u>not</u> received	
a Scholarship for Students of Exceptional Financial Need (EFN) under former sec Health Service Act (applicable to medical and dental students only).	ction 758 of the Public
SUBMITTED BY:	
Signature & Date:	
Name:	
Title & Phone Number:	
E-Mail Address: Name of School:	

Student may upload signed form to the NHSC SP Online Application: https://programportal.hrsa.gov/