OMB Number: 2900-0793
Estimated Burden: 10 minutes

Department of Veterans Affairs

Health Professional Scholarship Program (HPSP), Visual Impairment and Orientation and Mobility Professionals Scholarship Program (VIOMPSP), Veterans Healing Veterans Medical Access and Education Scholarship Program (VHVMAESP)

Request for Deferment

A participant may request a deferment of obligated service to complete an approved program of advanced clinical training.
This document represents a request from you to delay the start of your Department of Veterans Affairs service obligation.

Return the completed form to:
Scholarships and Clinical Education Program Office
Department of Veterans Affairs
1250 Poydras St., Suite 1000
New Orleans, LA 70113.

PRIVACY ACT NOTICE

The VA is asking you to provide the information on this form under the authority of 38 U.S.C. §7501 (VIOMPSP), §7611 (HPSP), and §7601 (VHVMAESP) in order for VA to administer your 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 continue your scholarship award. If you give VA your social security number, VA will use it to obtain information relevant to administering your scholarship award. It also may be used for other purposes authorized or required by law.

☐ HPSP ☐ VIOMPSP ☐ VHVMAESP

Participant's Name *(Last, First, Middle):*	Social Security Number:
Address *(Include Street Address, City, State, and ZIP Code):*	Phone Number:
	Email Address:

Type of residency/fellowship/clinical program you wish to attend:	Length of program:	Program start date:	Anticipated date available for service obligation:

Is your selection for this residency/fellowship/clinical program through a national match program? ☐ Yes ☐ No	If yes, title of the match program:	What is the notification date?:

Are all match sites/locations that you have applied to accredited by the nationally recognized accrediting body? ☐ Yes ☐ No	Name of accrediting body:

Name and location of residency/fellowship/clinical site if known: _____

Name, address and telephone number (other than your own) of a person through whom you may always be reached:

Name of Secondary Contact *(Last, First, Middle):*	Phone Number:
Address *(Include Street Address, City, State, and ZIP Code):*	

If you have any questions please contact the Department of Veterans Affairs, Scholarships and Clinical Education Program Office at HPSPTeam@va.gov

_____ Signature

_____ Date