![HRSA Nurse Corps logo]

BUREAU OF HEALTH WORKFORCE

VERIFICATION OF ACCEPTANCE/GOOD STANDING REPORT

This Verification of Acceptance/Good Standing Report certifies that the student identified below has been accepted for admission or is enrolled in good standing in the nursing degree program in which student is applying for the 2020-2021 academic year as indicated. (To be completed by a school official only.)

1. Student's Name (Last, First, Middle)   2. Student's Social Security Number (**Last 4 digits ONLY**)

_____ |____|____|____|____|

3. Nursing program the student is enrolled in for the academic term 2020-2021:

Diploma ☐ | Associate (ADN) ☐ | Baccalaureate (BSN) ☐ | Accelerated BSN (ABSN) ☐ |

Masters (MSN-NP): Specialty _____ ☐ |

Direct Masters Entry NP: Specialty _____ ☐ |

Masters (MS-Other): Please Explain _____ ☐ |

MSN RN Generalist ☐ | Doctoral (DNP) ☐ |

4. When will/did the student enter the nursing program for which funding is being requested: (mm/yy): _____

5. Is the student in good academic standing?   Yes ☐   No ☐

6. Is the student considered Full-Time or Part Time in the nursing program? Full-Time ☐ Part-Time ☐

7. Length of the full-time nursing program (years and/or months): _____

8. Date professional nursing classes begin for the 2020-2021 academic year (mm/yy): _____

9. Nursing program end date (Completion of required classes for graduation) (mm/yy): _____

10.   Anticipated date of graduation (mm/yy): _____

11.   Students total cumulative Grade Point Average (GPA): _____

12. Is there a contingency to the students acceptance to the program? Examples include the student needing to repeat a course or having received and "Incomplete" status for a course   Yes ☐   No ☐

    If yes, please explain: _____

(All contingencies must be met by the start of the Fall 2020-2021 term.)

13. Nursing Program Accreditation (The NCSP will only fund students attending fully accredited institutions)
Name of National or Regional Accreditation Organization: _____

Accreditation Expiration / Renewal Date: (mm/yy): _____

Is accreditation provisional? Yes ☐   No ☐

School Information   **Nursing School Official Contact Information**

Name of School: _____   Name & Title: _____

Address: _____   Phone Number: _____ Fax: _____

_____   E-mail Address: _____

City: _____ State: _____ Zip Code: _____

By signing my name below, I certify that the information provided on this Verification of Acceptance/Good Standing Report is accurate and complete to the best of my knowledge and belief. I understand that any willfully false information may be punishable as a felony under U.S. Code, Title 18, Section 1001.

Signature of Nursing School Official: _____ Date _____

![Department of Health & Human Services seal] ![HRSA Health Resources & Services Administration logo]

Must be received by April 30, 2020 at 7:30 pm ET.
Please upload to the Nurse Corps SP Portal: https://programportal.hrsa.gov/