ACADEMIC FACULTY/ADVISOR EVALUATION FORM Instructions

Applicant:
Mail or e-Mail the attached evaluation form, along with this instruction page to your evaluator.

Ensure that your designated ACADEMIC evaluator has received, completed, signed and mailed their evaluation directly to NHHSP.

NOTE: The Academic Faculty/Advisor Evaluation form is MANDATORY.

Evaluator:
Complete and mail the attached form directly to:

Native Hawaiian Health Scholarship Program ATTN: NHHSP Operations Coordinator
894 Queen Street
Honolulu, HI 96813

REMINDER: THE ATTACHED FORM MUST BE MAILED TO NHHSP NO LATER THAN MARCH 1, 2017.

If you have any questions, contact the NHHSP Operations Coordinator at (808) 597-6550 ext. 203 or adminassist@nhhsp.org

U. S. Department of Health and Human Services HEALTH RESOURCES & SERVICES ADMINISTRATION
Bureau of Health Workforce PAPA OLA LOKAHI

Title 42 Chapter 122 Section 11709– Native Hawaiian Health Scholarship Program

APPLICANT'S NAME	eMAIL ADDRESS	PHONE: ☐ CELL ☐ HOME
COLLEGE / UNIVERSITY		PROJECTED Graduation MO/YR

The student/NHHSP Applicant, identified above, is applying for a Scholarship with the Native Hawaiian Health Scholarship Program (NHHSP). The requested information is pursuant to Section 751-756 of the Public Health Service Act, and the applicable program regulations which provide for consideration be given, based on academic faculty/advisor recommendation when evaluating and selecting individuals for scholarships.

The information provided on this form is treated as confidential and may only be disclosed outside the U. S. 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.*

Return this completed & signed 'ACADEMIC EVALUATION' Form #1 to NHHSP

1. How do you rate the educational and/or work achievement of this Applicant?

5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 1 - ☐ 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 1 - ☐ 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 Provider Shortage Area (HPSA)?

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

EMPLOYER EVALUATION FORM
Instructions

Applicant:
Mail or eMail the attached evaluation form, along with this instruction page to your evaluator.

Ensure that your designated EMPLOYER evaluator has received, completed, signed and mailed the evaluation form directly to NHHSP.

NOTE:
If you are currently **unemployed**, a Community Resource/Personal Reference Evaluation form may be completed and submitted in lieu of an Employer Evaluation form.

Evaluator:
Complete and mail the attached form directly to:

Native Hawaiian Health Scholarship Program ATTN: NHHSP Operations Coordinator
894 Queen Street
Honolulu, HI 96813

REMINDER: THIS FORM MUST BE SUBMITTED TO NHHSP NO LATER THAN MARCH 1, 2017.

If you have any questions, contact the NHHSP Operations Coordinator at (808) 597-6550 ext. 203 or adminassist@nhhsp.org

U. S. Department of Health and Human Services HEALTH RESOURCES & SERVICES ADMINISTRATION

Bureau of Health Workforce PAPA OLA LOKAHI

Title 42 Chapter 122 Section 11709– Native Hawaiian Health Scholarship Program

NHHSP APPLICANT'S NAME	eMAIL ADDRESS
APPLICANT'S place of Employment	PHONE: ☐ CELL ☐ HOME

The NHHSP Applicant, identified above, is applying to receive a Native Hawaiian Health Scholarship Program (NHHSP) scholarship. The information on this form is requested pursuant to Section 751-756 of the Public Health Service Act, and the applicable program regulations which provide for consideration be given, based on employer recommendation, when evaluating and selecting individuals for scholarships.

The information provided on this form is treated as confidential and may only be disclosed outside the U. S. 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.*

Return this completed & signed 'EMPLOYER EVALUATION' Form #2 directly to NHHSP

1. How do you rate the educational and/or work achievement of this Applicant?

____

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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 1 - ☐ 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 Provider Shortage Area (HPSA)?

5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 1 - ☐ POOR

Comments:____

____

____

4. Relationship to NHHSP Applicant:____

5. Length of time known: ____

***If more space is required, use additional sheets of 8.5x11" paper. Write your name and social security number on each additional sheet of paper/ Securely attach additional sheets to this form*

Statement of Conflict of Interest: I certify I am not related to NHHSP 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 for rejection of this application.

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

COMMUNITY RESOURCE / PERSONAL REFERENCE EVALUATION FORM Instructions

Applicant:
Print and mail or eMail the attached evaluation form, along with this instruction page to your evaluator.

Ensure that your designated COMMUNITY RESOURCE/PERSONAL REFERENCE evaluator has received, completed, signed and mailed their evaluation directly to NHHSP.

Evaluator:
Complete and mail the attached form **directly** to:

Native Hawaiian Health Scholarship Program ATTN: NHHSP Operations Coordinator
894 Queen Street
Honolulu, HI 96813

REMINDER: THIS FORM MUST BE SUBMITTED TO NHHSP NO LATER THAN MARCH 1, 2017.

If you have any questions contact the NHHSP Operations Coordinator at (808) 597-6550 ext. 203

U. S. Department of Health and Human Services HEALTH RESOURCES & SERVICES ADMINISTRATION

Bureau of Health Workforce PAPA OLA LOKAHI

Title 42 Chapter 122 Section 11709– Native Hawaiian Health Scholarship Program

NHHSP APPLICANT'S NAME APPLICANT'S relationship to Evaluator	eMAIL ADDRESS PHONE: ☐ CELL ☐ HOME

The NHHSP Applicant, identified above, is applying to receive a Native Hawaiian Health Scholarship Program (NHHSP) scholarship. The requested information on this form is pursuant to Section 751-756 of the Public Health Service Act, and the applicable program regulations which provide for consideration be given, based on community resource or personal reference recommendation, when evaluating and selecting individuals for scholarships.

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*.

Return this completed & signed **'**COMMUNITY RESOURCE/PERSONAL REFERENCE' Form #3 **directly** to NHHSP.

1. How do you rate the educational and/or work achievement of this Applicant?

5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 1 - ☐ 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 1 - ☐ 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 Provider Shortage Area (HPSA)?

5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 1 - ☐ POOR

Comments:

4. Applicant's role/job at Community Agency:

5. Length of time known:

***If more space is required, use additional sheets of 8.5x11" paper. Write your name and social security number on each additional sheet of paper/ Securely attach additional sheets to this form*

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

NAME (Print or type)	
Position Title (at Community Agency)	ame of Community Agency
SIGNATURE	DATE

N