



**ACCEPTANCE REPORT/VERIFICATION OF GOODSTANDING**

This Acceptance Report/Verification of Good Standing certifies that the student identified below has been accepted for full-time admission or is enrolled in full-time and in good standing for the 2020-2021 school year (i.e., July 1, 2020 – June 30, 2021) as indicated. Please note all information will be verified for accuracy. (To be completed by a school official only). If the applicant is newly accepted to the program, complete sections A and C. For continuing students complete sections B and C.

Section A – Newly Accepted Students

1. Student’s Name (Last, First, Middle): \_\_\_\_\_ 2. Student’s SSN (Last 4 digits): \_\_\_\_\_

3. Is the student in good standing?  Yes  No

(If NO, please explain.) \_\_\_\_\_

4. Degree/certificate the student will receive upon completion of the program: \_\_\_\_\_

5. Student year in program as of the 2020-2021 school year: 1<sup>st</sup>  2<sup>nd</sup>  3<sup>rd</sup>  4<sup>th</sup>

6. Is there a contingency to the student’s acceptance to the program other than standard contingencies that apply to all admitted applicants? Examples include the student needing to repeat a course or the student receiving an “Incomplete” status for a course. Yes  No

If YES, please explain: \_\_\_\_\_

(All contingencies must be met by June 30, 2020)

7. What schedule/system does the school year operate on?  Semester  Quarter  Trimester  
 Other (Please explain) \_\_\_\_\_

8. Length of the full-time program (months or years) \_\_\_\_\_

9. Date class begins for the school year 2020-2021 (mm/dd/yyyy): \_\_\_\_\_

10. Anticipated date of graduation (mm/dd/yyyy): \_\_\_\_\_

Section B – Continuing Students

1. Student’s Name (Last, First, Middle): \_\_\_\_\_ 2. Student’s SSN (Last 4 digits): \_\_\_\_\_

3. What program is the student admitted to? (Please specify if the program is a dual degree or bridge program.)  
\_\_\_\_\_

3. Is the student in good standing?  Yes  No

(If No, please explain.) \_\_\_\_\_

4. Degree/certificate the student will receive upon completion of the program: \_\_\_\_\_



**National Health Service Corps  
Scholarship Program**  
U.S. Department of Health and Human Services  
Health Resources and Services Administration

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5. Student classification as of the 2019-2020 school year: 1<sup>st</sup>  2<sup>nd</sup>  3<sup>rd</sup>  4<sup>th</sup>

6. Student Status (check all that is applicable):  Full-Time Enrollment  Part-Time Enrollment  
 Repeating Coursework  On Academic Probation  On a Leave of Absence  Withdrawn  
 Other (please explain) \_\_\_\_\_

7. What schedule/system does the school year operate on?  Semester  Quarter  Trimester  
 Other (Please explain) \_\_\_\_\_

8. Length of the full-time program (months or years) \_\_\_\_\_

9. Date student began the program (mm/dd/yyyy) \_\_\_\_\_

10. Anticipated date of graduation (mm/dd/yyyy): \_\_\_\_\_

**Section C**

By signing my name below, I certify that the current status of the student listed above has been correctly identified. I further certify that, where necessary, I have corrected the "Year in Program" and "Date of Graduation" for the student to accurately reflect the anticipated graduation date given the current enrollment. I understand that any willfully false information may be punishable as a felony under U.S. Code, Title 18, Section 1001.

**SUBMITTED BY:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ E-Mail \_\_\_\_\_ Address: \_\_\_\_\_  
Name of School: \_\_\_\_\_

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

**Public Burden Statement:** The purpose of the NHSC SP, NHSC S2S LRP, and the NHHSP is to provide scholarships or loan repayment to qualified students who are pursuing primary care health professions education and training. In return, students agree to provide primary health care services at approved facilities located in designated Health Professional Shortage Areas (HPSAs) once they are fully trained and licensed health professionals. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0146 and it is valid until XX/XX/202X. This information collection is required to obtain or retain a benefit (NHSC SP: Section 338A of the PHS Act and Section 338C-H of PHS Act; NHSC S2S LRP: Section 338B of the PHS Act and Section 331(i) of the PHS Act; NHHSP: The Native Hawaiian Health Care Improvement Act of 1992, as amended [42 U.S.C. 11709]). Public reporting burden for this collection of information is estimated to average xx hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or [paperwork@hrsa.gov](mailto:paperwork@hrsa.gov).