OMB Number: 0915-0146
Expiration Date: xx/xx/xxxx

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

NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM

AUTHORIZATION TO RELEASE INFORMATION

If I become a participant in the National Health Service Corps (NHSC) Scholarship Program, I, _____, hereby authorize:
(Print Name - Last, First, Middle Initial)

1) The school where I am/was enrolled while participating in the NHSC Scholarship Program to disclose information pertaining to my school enrollment to the Department of Health and Human Services (DHHS), and/or its contractors. Information pertaining to my school enrollment includes, but is not limited to, my transcripts and grades, academic standing, enrollment and degree status, curriculum and examination requirements for graduation, tuition and fees, leave-of-absence, withdrawal, or dismissal from school. This information will be used by DHHS to determine my eligibility to continue to receive scholarship benefits and the amount of those benefits.

2) If applicable, I hereby authorize any postgraduate training program(s), for which I receive a deferment (i.e., approval) from DHHS to complete, to disclose to DHHS, and/or its contractors, information pertaining to my participation in the postgraduate training program(s) including, but not limited to, my curriculum and examination requirements, status in the program, completion date, leave-of-absence, withdrawal or dismissal from the program.

3) The entity/entities where I am/was approved to provide service in satisfaction of my NHSC Scholarship Program obligation to disclose to DHHS, and/or its contractors, information pertaining to my compliance with the NHSC scholarship service requirements. Such information includes, but is not limited to, my practice location(s), practice responsibilities, work schedule or other documentation indicating the hours that I worked and the hours I was away from the site, records relating to my work performance and (if applicable) the circumstances relating to the termination of my employment at the service location.

The above authorizations take effect on the date that I become a participant in the NHSC Scholarship Program and shall remain in effect until the date my NHSC scholarship commitment has been fulfilled.

In addition, I hereby authorize the DHHS, and/or its contractors, to release my name, address(es) and social security number to see if I appear on the Excluded Parties List System. This authorization takes effect on the date I sign this release form. If I do not become a participant, this authorization shall remain in effect until September 30, 2020.

These authorizations may be revoked by me in writing at any time.

_____ _____
(Signature of Individual) (Date)

Please upload the completed and 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/xxxx. 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 hour 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.