OMB Number: 0915-0146
Expiration Date: xx/xx/20xx

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

ACCEPTANCE REPORT/VERIFICATION OF GOOD STANDING

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 202x-202x 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 202x-202x school year: 1st ☐ 2nd ☐ 3rd ☐ 4th ☐

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, 202x)

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 202x-202x (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: _____

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5. Student classification as of the 202x-202x school year: 1st ☐ 2nd ☐ 3rd ☐ 4th ☐

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☐ Repeating Coursework ☐ On Academic Probation ☐ On a Leave of Absence ☐ Withdrawn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, Section 338C-H of PHS Act; NHSC S2S: Section 338B and Section 331(i) of the PHS Act; NHHSP: 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.