



Scholar Enrollment Verification Form (EVF)

This document is to verify that you are in good academic standing at your school of record. Please complete **all** required fields and return the form with a copy of your most recent unofficial transcript with last semester grades through the Customer Service Portal at <https://programportal.hrsa.gov>. Failure to submit this form or accurately complete all required information fields may delay your NHSC SP Tuition and Stipend payments.

Select all terms enrolled for entire school year: Summer___ Fall___ Winter___ Spring___ Block___

PERSONAL INFORMATION

Name: _____	Phone (Day) : _____
Mailing Address: _____	Phone (Evening): _____
City: _____ State: _____ Zip: _____	Email (Primary): _____
	Email (Secondary): _____

PROGRAM INFORMATION

School Name: _____ State: _____	Did your graduation date change: <input type="checkbox"/> Yes <input type="checkbox"/> No
Program Length: _____ Year in Program: _____	If yes, new graduation date: _____/_____/_____ MM DD YYYY
Discipline & Specialty: _____	Is this your final year: <input type="checkbox"/> Yes <input type="checkbox"/> No
Is your Transcript with last semester grades attached: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, last day of class: _____/_____/_____ MM DD YYYY

SELECT YOUR CURRENT IN-SCHOOL STATUS BELOW (Check all that apply)

<input type="checkbox"/> Full-Time (in good academic standing) <input type="checkbox"/> Part-Time* <input type="checkbox"/> No Term (no classes this semester) <input type="checkbox"/> Repeating coursework-not on academic probation* <input type="checkbox"/> Repeating coursework-on academic probation* <input type="checkbox"/> Other status (explain)*	<input type="checkbox"/> On academic probation* _____/_____/_____ to _____/_____/_____ MM DD YYYY MM DD YYYY	<input type="checkbox"/> On an approved leave of absence* _____/_____/_____ to _____/_____/_____ MM DD YYYY MM DD YYYY
	<input type="checkbox"/> Declining Support from _____/_____/_____ to _____/_____/_____ MM DD YYYY MM DD YYYY	<input type="checkbox"/> Withdraw/Dismissed from school* _____/_____/_____ MM DD YYYY

***Any status other than full-time requires an attached confirmation letter from the school and a separate explanation from the scholar.**

Scholar's Signature _____	Date _____	School Official's name _____
		Phone: _____
		Email: _____
School Official's Signature _____	Date _____	

I certify that the above information on this EVF is accurate and complete to the best of my knowledge and belief. I understand that any willfully false statements made herein may be investigated and be punishable as a felony under U.S. Code, Title 18, section 1001.

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.