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

Scholar Enrollment Verification Form Instructions

THE DEADLINE FOR THIS FORM IS THE START DATE OF EACH ACADEMIC TERM!

The purpose of the Scholar Enrollment Verification Form (SEVF) is for the school to verify that an NHHSP Scholar is currently enrolled and registered for courses.

Please ensure that the SEVF is filled out by a school official, and all required information is provided. **Your stipend and tuition payments will be delayed or placed on hold for the entire semester** if the SEVF is not properly completed or turned in by the start date of that particular semester.

- Include school name and state of college/university location.
- Include last 4-digits of the SSN #.
- School official must fill out the SEVF and provide contact information with signature.
- **The SEVF requires the school's seal and/or stamp**; NHHSP Scholars are to determine the appropriate school representative to provide this verification (i.e., academic advisor, the Business office, the Registrar's office, the Bursar's office, Dean of the School, etc.)
- Attach a copy of your current registered course schedule to the SEVF (i.e., a print-out or screenshot of the School's portal or student's online account, a hardcopy issued by the Registrar's office and/ or the scholar's academic advisor, etc.) **An official school seal or stamp must be present** on the attached document.
- Attach a copy of a Transcript Request receipt, indicating that you will be submitting the most current official transcripts at the completion of the term. The transcripts must include the term grades for the courses previously verified by the SEVF.

Scholar Enrollment Verification Form

The DEADLINE for this form is the Start Date of each academic term

THIS FORM IS TO BE COMPLETED BY A SCHOOL OFFICIAL & MAILED TO NHHSP AT:* **894 QUEEN STREET HONOLULU, HI 96813

CURRENT CYCLE (check one): ☐ Summer ☐ Fall ☐ Winter ☐ Spring	YEAR:	Anticipated Date of Graduation (MM/YYYY):

Name of College/University:_____ **State:**_____

Scholar's Name:_____ **Discipline:**_____

SSN (Last 4 digits): _____

Scholar's Current Status (check-mark all that may apply):

☐ #1 ☐ #2 ☐ #3 ☐ #4 #5 #6

INDICATE THE SCHOLAR'S CURRENT ENROLLMENT STATUS ABOVE BY REFERENCING THE CATEGORIES:

1 = Full-Time Enrollment
2 = Part-Time Enrollment
3 = Repeating Course Work
4 = Leave of Absence
5 = Withdrawn / Dropped out of School
6 = Other Status (explain below)

Explain/Comments:

_____

_____

_____

By signing my name below, I certify that the current status of the scholar listed above has been correctly identified from the categories provided. I also attest that the attached Registered Course Schedule has been verified as the scholar's enrollment for the current term.

SIGNATURE:_____ DATE:_____

PRINT NAME:_____ TITLE:_____

PHONE NUMBER:_____ EMAIL:_____

ADDRESS:_____ FAX NUMBER: _____

School Seal/Stamp

**raised seal— shade with pencil*

FOR NHHSP USE ONLY:

Any changes to The Academic Plan (curriculum)?____YES_____NO

☐ No change to the Academic Plan.

☐ Change noted; Change in Program Curriculum submitted.

NHHSP Initials _____

Any changes to The Financial Plan?____YES_____NO

☐ No change to the Financial Plan.

☐ Change noted; Scholar Financial Plan amended.

Date Verified _____

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.

QUESTIONS? Contact NHHSP at (808)597-6550