

U.S. Department of Health and Human Services
Health Resources & Services Administration
Papa Ola Lōkahi



Title 42 USC Chapter 122 Section 11709 – Native Hawaiian Health Scholarship
Acceptance/Verification of Good Standing Form - Program Course Curriculum

APPLICANTS' NAME

DEGREE(i.e., masters of science in nursing)

COLLEGE/UNIVERSITY NAME

PROJECTED GRADUATION MO/YR

THIS Program Course Curriculum document MUST BE COMPLETED and RETURNED to NHHSP

APPLICANT applied for Admission or is Enrolled at above-mentioned College/University since/for the **Academic Year 20__ - 20__**. APPLICANT will be enrolled OR is anticipated to be enrolled Full-Time in an undergraduate/graduate degree-seeking program (identified above) for the Academic Year **202x-202x**.

LIST Degree Program CURRICULUM from (start of) FIRST YEAR to COMPLETION

e.g. FALL 2020 Months: August - December

Summer _____ (Year)	Months: _____	Year One
Course Number	Credit Hours	Course Title
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Fall _____ (Year)	Months: _____	
Course Number	Credit Hours	Course Title
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NHHSP Applicant Signature

Date

Spring _____ (Year)

Months: _____

Course Number

Credit Hours

Course Title

Summer _____ (Year)

Months: _____

Year Two

Course Number

Credit Hours

Course Title

Fall _____ (Year)

Months: _____

Course Number

Credit Hours

Course Title

Spring _____ (Year)

Months: _____

Course Number

Credit Hours

Course Title

Summer _____ (Year)

Months: _____

Course Number

Credit Hours

Course Title

Fall _____ (Year)

Months: _____

Course Number

Credit Hours

Course Title

Spring _____ (Year)

Months: _____

Course Number

Credit Hours

Course Title

Summer _____ (Year)

Months: _____

Course Number

Credit Hours

Course Title

Year Four

Fall _____ (Year)

Months: _____

Course Number

Credit Hours

Course Title

Spring _____ (Year)

Months: _____

Course Number

Credit Hours

Course Title

_____ (Term) _____ (Year)

Months: _____

Course Number

Credit Hours

Course Title

_____ (Term) _____ (Year)

Months: _____

Course Number

Credit Hours

Course Title

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.