DEPARTMENT OF HEALTH AND HUMAN SERVICES

Nurse Corps Scholarship Program

HRSA Health Resources & Services Administration

Student Enrollment Verification Form

THIS FORM IS TO BE COMPLETED BY A SCHOOL OFFICIAL

School Name	State	Program Year	Term	Year
		1 ☐ 2 ☐ 3 ☐ 4	Summer	2022
Name (Last, First, MI)	**Nursing Program Completion Date**	**Term/Semester Start Date**	**Term/Semester End Date**	**Graduation Date**

	Enrolled Degree Program
☐	Diploma
☐	ADN
☐	BSN
☐	ABSN
☐	MN
☐	Direct Entry Masters-NP
☐	MSN-NP
☐	DNP
☐	Other (Explain)

Explain:

Enrolled Degree Program. Please indicate the student's current enrollment status by selecting which of the following categories apply. Check more than one category if necessary. Also, if applicable, list a new graduation date in the comment's column.

☐	Full-Time Enrollment in Nursing Program
☐	Part-Time Enrollment in Nursing Program
☐	Repeating Course Work
☐	Leave of Absence
☐	Withdrawn/ Dropped out of School
☐	Not Enrolled (Summer Only)
☐	Other Status (please explain)

Explain/Comments:

School Seal/Stamp
*raised seal - shade with pencil or crayon

Specialty for NPs and Direct Entry Masters NPs

Specify:

By signing my name below, I certify that the current status of the student listed above has been correctly identified from the categories provided above.

School Representative Signature		**Date**	
Print Name		**Title**	
Phone Number		**Email Address**	
Address		**Fax Number**	

For questions on how/where to submit this form please contact the Customer Care Center at: 1-800-221-9393

Public Burden Statement: The purpose of the Nurse Corps Scholarship Program (Nurse Corps SP) is to provide scholarships to nursing students in exchange for a minimum two-year full-time service commitment (or part-time equivalent), at an eligible health care facility with a critical shortage of nurses. The information that applicants supply is used to evaluate their eligibility, qualifications and to assess their continued compliance with the applicable standards for participation in the Nurse Corps SP. The OMB control number for this information collection is 0915-0301 and it is valid until xx/xx/xx. This information collection is required to obtain a benefit (Section 846(d) of the Public Health Service Act (42 United States Code 297n (d)), as amended). Data will be private to the extent permitted by the law. Public reporting burden for this collection of information is estimated to average approximately 36 minutes 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 14NWH04, Rockville, Maryland, 20857.

Form Approved| OMB No. 0915-0301 |Expires xx/xx/xxxx