Native Hawaiian Health Scholarship Program
U.S. Department of Health and Human Services
Health Resources and Services Administration
OMB No: 0915-0146
Expiration Date: xx/xx/xxxx

Scholar Enrollment Verification Form Instructions

THE DEADLINE FOR THIS FORM IS AS SOON AS POSSIBLE AFTER THE ADD/DROP DATE OF EACH ACADEMIC TERM

The purpose of the Scholar Enrollment Verification Form (SEVF) is for the school to verify that a Native Hawaiian Health Scholarship Program (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.
- 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.

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

**THIS FORM IS TO BE COMPLETED BY A SCHOOL OFFICIAL & EMAILED TO NHHSP AT nhhsp@papaolalokahi.org.*

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): _____ **College/University Unique Entity Identifier:** _____

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.

Any changes to The Financial Plan?____YES_____NO
☐ No change to the Financial Plan.
☐ Change noted; Scholar Financial Plan amended.

NHHSP Initials

Date Verified

Public Burden Statement: The purpose of this information collection is to obtain information through the Native Hawaiian Health Scholarship Program, which is used to assess an applicant's eligibility and qualifications for the NHHSP. Clinicians interested in participating in the NHHSP must submit an application to the NHHSP, which is administered by Papa Ola Lokahi. 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/xxxx. This information collection is required to obtain or retain a benefit (The Native Hawaiian Health Care Improvement Act of 1992, as amended [42 U.S.C. 11709]). The information is protected by the Privacy Act, but it may be disclosed outside the U.S. Department of Health and Human Services, as permitted by the Privacy Act and Freedom of Information Act, to Congress, the National Archives, and the Government Accountability Office, and pursuant to court order and various routine uses as described in the System of Record Notice 09-15-0037. Public reporting burden for this collection of information is estimated to average xx hour 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.

QUESTIONS? Contact NHHSP at nhhsp@papaolalokahi.org.