U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

OMB No: 0915-0146
Expiration Date: xx/xx/xxxx

U. S. Department of Health and Human Services
HEALTH RESOURCES & SERVICES ADMINISTRATION
Bureau of Health
Workforce PAPA OLA
LOKAHI

Title 42 Chapter 122 Section 11709– Native Hawaiian Health Scholarship Program Recommendation Form/Academic Evaluation Form - *We will not accept letters of recommendation.*

APPLICANT'S NAME	eMAIL ADDRESS	PHONE: ☐ CELL ☐ HOME
COLLEGE / UNIVERSITY		PROJECTED Graduation MO/YR

The student/Native Hawaiian Health Scholarship Program (NHHSP) Applicant, identified above, is applying for a Scholarship with the NHHSP. The requested information is pursuant to Section 751-756 of the Public Health Service Act, and the applicable program regulations which provide for consideration be given, based on academic faculty/advisor recommendation when evaluating and selecting individuals for scholarships.

The information provided on this form is treated as confidential and may only be disclosed outside the U. S. Department of Health and Human Services in accordance with provisions of the Privacy Act of 1974 (P.L. 93-579) and the terms and conditions of the applicable Privacy Act Notice published by the Department in the *Federal Register.*

Return this completed & signed 'ACADEMIC EVALUATION' Form to NHHSP

1. How do you rate the educational and/or work achievement of this Applicant?

5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 1 - ☐ POOR

Comments:_____

2. How do you rate the Applicant's relationships with other people? Consider such things as ability to work and get along with others. 5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 1 - ☐ POOR

Comments:_____

3. Based on this Applicant's personal, emotional, and ethical attributes, how do you rate his/her overall potential for the practice of primary health care, especially in a Health Provider Shortage Area (HPSA)?

5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 1 - ☐ POOR

Comments:_____

4. Relationship to NHHSP Applicant:_____

5. How long have you known the Applicant? _____

Statement of Conflict of Interest: I certify I am not related to NHHSP Applicant by blood or marriage.

I certify that the information provided in this evaluation is accurate. I understand that it may be investigated and that any willfully false representation is sufficient for rejection of this application.

NAME (Print or type)		
POSITION TITLE (Required)	PLACE OF EMPLOYMENT (Required)	
SIGNATURE		DATE

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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.

For questions on how/where to submit this form please contact the NHHSP at nhhsp@papaolalokahi.org.