



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

**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 Program  
Acceptance/Verification of Good Standing Form**

APPLICANT'S/SCHOLAR'S 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

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
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**Fall \_\_\_\_\_ (Year)**

**Months: \_\_\_\_\_**

Course Number

Credit Hours

Course Title

|       |       |       |
|-------|-------|-------|
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NHHSP Applicant Signature

Date

**Spring \_\_\_\_\_ (Year)**

**Months: \_\_\_\_\_**

Course Number

Credit Hours

Course Title

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**Summer \_\_\_\_\_ (Year)**

**Months: \_\_\_\_\_**

Course Number

Credit Hours

Course Title

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**Fall \_\_\_\_\_ (Year)**

**Months: \_\_\_\_\_**

Course Number

Credit Hours

Course Title

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**Spring \_\_\_\_\_ (Year)**

**Months: \_\_\_\_\_**

Course Number

Credit Hours

Course Title

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**Summer \_\_\_\_\_ (Year)**

**Months: \_\_\_\_\_**

**Year Three**

| Course Number | Credit Hours | Course Title |
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| Fall _____ (Year) | Months: _____ |              |
|-------------------|---------------|--------------|
| Course Number     | Credit Hours  | Course Title |
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| Spring _____ (Year) | Months: _____ |              |
|---------------------|---------------|--------------|
| Course Number       | Credit Hours  | Course Title |
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| Summer _____ (Year) | Months: _____ | Year Four    |
|---------------------|---------------|--------------|
| Course Number       | Credit Hours  | Course Title |

| Fall _____ (Year) | Months: _____ | Year Four |
|-------------------|---------------|-----------|
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| Course Number | Credit Hours | Course Title |
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| Spring _____ (Year) | Months: _____ |              |
|---------------------|---------------|--------------|
| Course Number       | Credit Hours  | Course Title |
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| _____ (Term) _____ (Year) | Months: _____ |              |
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| Course Number             | Credit Hours  | Course Title |
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| _____ (Term) _____ (Year) | Months: _____ |              |
|---------------------------|---------------|--------------|
| Course Number             | Credit Hours  | Course Title |
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**Public Burden Statement:** The purpose of this information collection is to obtain information through the Native Hawaiian Health Scholarship Program that is used to assess a scholarship applicant's eligibility and qualifications for the NHHSP. Clinicians interested in participating in the NHHSP must submit an application to the Native Hawaiian Health Scholarship Program. 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 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 14NWH04, Rockville, Maryland, 20857.