

Health Professions Education Scholarship Application



Postmark Deadline:
September 11, 2012

Application materials postmarked after the deadline will not be reviewed. Faxed copies will not be accepted.

Giving Golden Opportunities by:

Increasing the supply of health professionals practicing in medically underserved areas.

Improving access to healthcare in rural and urban areas of California.

Helping students pursue a career in the health professions.

Awarding health professionals who are dedicated to practicing in underserved communities.

This program is funded by a grant from "The California Wellness Foundation".



HPSP Application Instructions

NOTE: This application is designed to be printed and filled in manually. To download the application you must have Adobe Reader. Go to www.adobe.com for a free copy of Adobe Reader.

The purpose of the Health Professions Education Scholarship Program (HPSP) is to increase the number of health professionals practicing in medically underserved areas of California. If awarded, the applicant agrees to provide direct patient care on a full time basis in a designated shortage area for a minimum of two (2) years.

Applications for the Health Professions Education Scholarship Program are accepted annually and awards up to **\$10,000**. Scholarships are intended to pay tuition, required fees, books, supplies, and educational equipment costs related to the applicant's registered nurse education.

The HPSP is administered by the Health Professions Education Foundation (Foundation) and is funded by a grant from "The California Wellness Foundation". All awards are subject to the availability of funding.



AM I ELIGIBLE?

To be eligible for the Health Professions Education Scholarship, the applicant must:

- be currently accepted or enrolled in one of the following health professional education program: nurse practitioner, clinical nurse specialist, certified nurse midwifery, physician assistant, dental hygiene or dentistry in California
- be free from any other service obligation
- have valid legal presence and ability to work and provide care in the state of California
- graduate after January 31, 2013
- be willing to work in a medically underserved area for two years
- submit a complete application that is postmarked on or before September 11, 2012

HOW DO I APPLY FOR THE SCHOLARSHIP?

For your application to be considered eligible for the HPSP, each of the items listed below must be sent in and filled out completely. It is highly recommended that applicants submit their applications before the postmark deadline. The Foundation will not notify applicants if their application is received incomplete. No documentation of any kind will be accepted by fax or e-mail. ALL MATERIALS MUST BE POSTMARKED BY THE DEADLINE OF SEPTEMBER 11, 2012.

Application & Document Checklist

	Completed Application: Application pages 1 - 7. Complete all entries and pages of this application. It must be completed, signed and dated to be considered eligible.
	Signatures on pages 3 and 7
	Personal Statement (2 pages, typed): Attach the personal statement to the application. Your statement must be typed and NO MORE THAN TWO (2) PAGES IN LENGTH. Any pages submitted in excess of two pages will not be read or taken into consideration. RESTATE AND NUMBER EACH QUESTION ALONG WITH THE ANSWER. Statements must provide a comprehensive response to each question. Personal Statements that lack detail may be considered incomplete and therefore, ineligible.
	Employment History: List up to four employers only if they are health related. Applicants will still be eligible even if no health related experience is listed.
	Graduation Date Verification (GDV): This form must be SIGNED BY THE PROGRAM DIRECTOR or an appropriate designee. The GDV is enclosed as part of this application.
	Two Letters of Recommendation: Letters of recommendation must be SIGNED and DATED within six (6) months of the application deadline (between March 2012 and September 2012). The letters must be on letterhead or include the author's title, name of employer, mailing address, and phone number. It is recommended that at least one letter be from a faculty member.
	Official Transcripts: The transcript must be sealed and marked "official" by the school. The Foundation WILL NOT ACCEPT UNOFFICIAL TRANSCRIPTS, copies or print outs of transcripts, or transcripts in an open/unsealed envelope. All post high school transcripts are required.
	Signed 2011 Federal Tax Return and W-2's or 2011/12 or 2012/13 Student Aid Report: DO NOT SUBMIT A STATE TAX RETURN. The State Tax Return will not be accepted in lieu of the Federal Tax Return. Include you and your spouse's (if applicable) W-2's. Student Aid Reports are furnished by FAFSA and include your Expected Family Contribution (EFC). You will turn in one or the other, not both.
	Cost of Attendance/Tuition: Please include a copy of the cost of attending the nursing program at your school.

WHAT IS THE SELECTION CRITERIA?

Awards are made on a competitive basis. Selection for the HPSP is based solely on information contained in the application and supporting documentation. Only complete applications will be evaluated.

Selection for awards is based on the following criteria:

- **Cultural and Linguistic Competence** – the applicant's ability to understand and respond effectively to the cultural and linguistic needs of patients.
- **Financial Need** - actual or potential difficulty in attending school in the absence of an award.
- **Work Experience** - health related work experiences
- **Career Goals** - short term and long term professional goals after becoming licensed.
- **Community Service** - documented volunteer service and/or activities you have been involved in. If none, you are still eligible.
- **Background** - how your family background, socio-economic, education and training have influenced your commitment to becoming a health professional and working in an underserved community.
- **Fluency** - Although it is not a requirement to speak a second language, fluency in a language other than English must be verified by the program director on the Graduation Date Verification (GDV) Form.

Glossary of Terms

Direct Patient Care: the provision of health care services directly to individuals being treated for, or suspected of having physical or mental illnesses. Direct patient care includes preventive care and first line supervision.

Economically Disadvantaged: a person whose gross family income at the time of application and the immediately preceding 2 years fell below 150 percent of the federally recognized poverty level.

Full Time Student: a student who is enrolled in a semester, trimester or quarter program of not less than 6 credit hours or units or their equivalent.

Medically Underserved Area (MUA): means any of the following:

- a. A Medically Underserved Area or Medically Underserved Population (MUA or MUP) as designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions' Shortage Designation Branch.
- b. A Primary Care Health Professional Shortage Area (HPSA) as designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions' Shortage Designation Branch.
- c. A California Primary Care Shortage Area as designated by

the California Healthcare Workforce Policy Commission.
d. A facility determined by the Director pursuant to section 128385 of the Health and Safety Code to be an eligible county health facility or an eligible state-operated health facility.

Scholarship: financial assistance provided to an eligible individual who agrees, in return for the assistance, to practice his or her profession for a specified period of time in a medically underserved area of the state.

Service Obligation: the contractual obligation agreed to by the recipient of a scholarship where the recipient agrees to practice their profession for a specified period of time in or through a designated facility.

Frequently Asked Questions

GENERAL

1. **Do I have to be a permanent California resident and U.S. citizen to apply for the HPE scholarship?** You must be have legal permanent residency in California to apply for all programs administered by the Health Professions Education Foundation. We do not require that you be a U.S. citizen.
2. **How many applicants are awarded each cycle through the HPSP?** The number of applicants awarded each cycle depends on the number of eligible HPSP applications received as well as the availability of funding. Each cycle is unique and the Foundation staff cannot predict the number of award recipients.
3. **How is the HPE scholarship funded?** Supported entirely through grants and contributions from public and private agencies, hospitals, health plans, foundations, corporations, and individuals.

APPLYING FOR THE SCHOLARSHIP

1. **When is the deadline to turn in an application?** The annual postmark for the HPSP is September 11. Make sure that the application you are using reflects the most current year. Updated applications are posted on our web site annually.
2. **Can I submit my application prior to the postmark deadlines?** You are encouraged to submit your HPSP application six (6) weeks prior to the postmark deadline in order for Foundation staff to verify that your packet is complete. Any documents submitted beyond the postmark deadline will not be accepted.
3. **May I request an extension to file my application if I cannot obtain all the required documents by the postmark deadline?** No. All documents must be postmarked by the application due date. No exceptions.

HPSP Frequently Asked Questions

This page does not need to be included with your application.

4. Can my letters of recommendation be sent directly to the Foundation or do I need to include them with my HPSP application? You can either have your letters of recommendation sent directly to our office or you can submit them along with your application packet. However, it is the applicant's responsibility to ensure that all documents are postmarked by the cycle deadline.

5. What is the maximum award amount for the HPSP and am I guaranteed to receive this full amount? The maximum award amount for the HPSP is up to \$10,000 for scholarships. Award recipients may not receive the full amount.

ELIGIBILITY

1. Who is eligible for an HPSP scholarship? Scholarships are available to students who are enrolled or accepted in an accredited in one of the following health professions education program: nurse practitioner, clinical nurse special, certified nurse midwifery, physician assistant, dental hygiene or dentistry in California. If you graduate prior to when awards are selected (January 2013) you are ineligible to apply. Priority will be given to students who will graduate within one year.

2. Can I still apply for the HPSP if I currently owe an existing service obligation? If you owe an existing service obligation to another entity, you are ineligible to apply with the Foundation until you have completed your existing obligation.

3. Can I apply for a Foundation scholarship if I attend school outside of California? No. You must be a California resident attending a California accredited college or University in order to receive a scholarship or loan repayment award from the Foundation.

4. Do I have to be bilingual in order to apply for the scholarship? No. You do not have to be bilingual in order to apply for the scholarship.

AFTER I'VE SUBMITTED MY APPLICATION

1. When will I be notified whether or not I have been selected to receive an award? The Foundation will notify applicants of the status their HPSP application via e-mail periodically until awards are announced.

2. If I am selected to be a scholarship recipient, does the money come directly to me or will it be sent to my school? Checks will be issued directly to the school on the recipient's behalf after the contract and certification has been sent back to the Foundation.

3. If I am selected to be a scholarship recipient for the HPSP, how many times can I reapply? HPSP recipients may apply once per academic year and be awarded the HPSP twice. However, there is no limit as to the number of times someone can apply. Note: Each scholarship awarded requires a two-year service obligation for each contract.

4. If I receive a scholarship, is it likely I will receive a subsequent scholarship? Being a current recipient does not increase or decrease your likelihood to receive a subsequent scholarship.

5. If I am NOT selected to be a scholarship recipient of the HPSP and I reapply again, do I need to resubmit my entire application or can the Foundation reuse the materials I have already submitted? HPSP applicants must resubmit a complete application packet each time they apply. The Health Professions Education Foundation will not reuse or send back any documentation previously submitted.

SIGNING A CONTRACT

1. If I am selected to be a scholarship recipient of the HPSP, what are the terms of my contractual obligation? All HPSP award recipients are required to graduate from the HPSP program, become licensed in CA and complete a two-year service obligation in a qualified facility providing direct patient care.

2. Does the Foundation job place or have a list of places that qualify for the service obligation? No, unfortunately the Foundation does not have the resources to job place or designate a facility for you. If awarded, it is your responsibility to find employment that complies with your contract. The Foundation does not maintain an updated list of all the facilities in California that qualify. Instructions to look up facilities are available on our website.

3. What happens if I am unable to fulfill the terms of my contractual obligation and cannot complete my service obligation? If an award recipient is unable to fulfill their contractual obligation, they will be required to repay all scholarship funds received, plus ten percent (10%) interest.

4. How do I determine which facility qualifies as a medically underserved area (MUA) or Health Professional Shortage Area? All county, state, VA, or prison facilities automatically qualify. Visit the Foundation's web site at www.healthprofessions.ca.gov and click the "MUA" on the menu bar. Follow the directions given. You will be asked to enter the address of the facility you wish to identify as a MUA or HPSA.

5. What happens if I need to change jobs during my service obligation? You have the option to change jobs during the term of your service obligation. However, in order to comply with the terms of your contract, you must remain employed with a qualified facility.

Submit applications to:

Health Professions Education Foundation

ATTN: HPE Scholarship Program

400 R Street, Suite 460

Sacramento, CA 95811

(800) 773-1669 or (916) 326-3640

PLEASE DO NOT STAPLE OR SUBMIT APPLICATIONS IN A
LOOSE LEAF BINDER



DO NOT STAPLE
APPLICATION

HPSP Scholarship Application

- ✓ Please refer to the application instructions when completing the application.
- ✓ Complete all pages of the application and make sure all supporting documents are submitted with your application.
- ✓ All documents must be postmarked by the application deadline of **SEPTEMBER 11, 2012**.
- ✓ Late or incomplete application packets or documents will not be evaluated. No exceptions.
- ✓ Copies of pages requiring original ink signatures will not be accepted.

PART A PERSONAL INFORMATION (Download and save this document to your computer.)

All personal and identifying information provided will remain private and confidential and will not be disclosed outside the HPESP award process.

Driver License or ID #				*Social Security #			
Mr.		Mrs.		Ms.		Dr.	
First Name						Middle Initial	
Last Name							
Street Mailing Address							
City						State	CA
Zip				County			
Home Phone				Cell Phone			
E-mail Address				Re-enter e-mail address			
Date of Birth				Male		Female	
Number of Dependents				Number of people in your household attending college			
Do you have valid legal presence in the U.S.?		YES		Will you be providing direct patient care in CA?		YES	
		NO				NO	

Racial/Ethnicity: (Please choose one) Collected for statistical purposes only.

<input type="checkbox"/>	African American	<input type="checkbox"/>	Asian American	<input type="checkbox"/>	Hispanic/Latino	<input type="checkbox"/>	Native American
<input type="checkbox"/>	Pacific Islander	<input type="checkbox"/>	White/Caucasian	<input type="checkbox"/>	Other (please specify)		

PART B QUESTIONNAIRE

Do you currently owe an existing service obligation to another entity? Please note: If you answer yes to this question, you do not qualify for this scholarship.	YES	NO
Are you a prior awardee of the Foundation? If yes, please enter the contract number	YES	NO
Are you the first in your family to attend college?	YES	NO

How did you hear about the HPE Scholarship Program? (Check all that apply)

<input type="checkbox"/>	School	<input type="checkbox"/>	Work
<input type="checkbox"/>	Friend/Acquaintance	<input type="checkbox"/>	Foundation Website
<input type="checkbox"/>	Twitter	<input type="checkbox"/>	Facebook
<input type="checkbox"/>	Advertisement (please specify)		
<input type="checkbox"/>	Newspaper or Publication (please specify)		
<input type="checkbox"/>	Organization or Affiliation (please specify)		
<input type="checkbox"/>	Conference (please specify)		
<input type="checkbox"/>	Other Source (please specify)		



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APPLICATION**

Last Name: _____

First Name: _____

PART C - LINGUISTIC COMPETENCY

1. List any languages in which you are fluent other than English. This must be verified by your director on the Graduation Date Verification form.

Language		Language	
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PART D - Program of Study Check which of the following health professional program you are studying.

- | | |
|----------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Clinical Nurse Specialist |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Dental Hygiene |
| <input type="checkbox"/> Certified Nurse Midwifery | <input type="checkbox"/> Dentistry |

PART E - PERSONAL STATEMENT

Attach your personal statement to the application. Your statement must be typed and no more than two (2) pages. Restate and number each question along with your answer. Personal statements that lack detail may be considered incomplete and therefore ineligible.

- Describe how your family background, education, training and life experiences have influenced your decision to pursuing a health professional career. Do you see your background as an advantage, disadvantage, or both?
- Describe how your family background, education, training and life experiences have influenced your commitment to working in a medically underserved area.
- Have you lived in an underserved or disadvantaged community? If so, please describe your experiences. If not, describe how you can relate to a community that is underserved or disadvantaged.
- After becoming a licensed health professional, describe your short term career goals (5 years) as it relates to providing direct patient care in a medically underserved area.
- After becoming a licensed health professional, describe your long term career goals (5+ years) as it relates to being a health professional in a medically underserved area.
- Give an example of how your life experiences and/or education have contributed to gaining an understanding of the cultural and linguistic needs of the medically underserved community.
- Please tell us your reasons for applying for this scholarship.
- List any community service, volunteer activities and/or professional organizations that you have been involved in the past five years. If none, please leave blank. To receive maximum credit, please provide a letter or documentation of your involvement including contact information for the organization: name, address and phone number.

Community Service	Start/End Dates	Your Role	Was this paid or required by your school or employer?	
			Y	N
			Y	N
			Y	N
			Y	N
			Y	N



DO NOT STAPLE
APPLICATION

Must be received by the postmarked deadline: **SEPTEMBER 11, 2012**

HPSP Program Graduation Date Verification Form

THIS SECTION IS TO BE FILLED OUT BY THE APPLICANT

Applicant's Last Name: _____ First Name: _____ MI: _____

School Name: _____

Program Enrolled: _____

School Mailing Address: _____

City: _____ State: CA Zip: _____ County: _____

THIS SECTION IS TO BE COMPLETED BY THE PROGRAM DIRECTOR OR AN APPROPRIATE DESIGNEE



ATTENTION! The completed form must bear an original ink signature. Photocopies and faxed copies of the completed form are not acceptable. This form must be sent in and postmarked by **September 11, 2012**. If this page is not SIGNED and DATED by the Program Director or an appropriate designee, the application will be considered INCOMPLETE and INELIGIBLE. The person signing this section may not be related to the applicant by blood, marriage, or adoption.

Date HPE program started				Expected Graduation Date from HPE program	
Enrollment Status	F/T		P/T	Grade Point Average	
Number of units currently enrolled (minimum of 6 units or equivalent modular units required)					

1. I verify that the applicant can speak the following language(s) in addition to English:

Language		Language	
----------	--	----------	--

2. I understand that I, should the applicant be awarded, agree to sign certifications that the student is in good standing and enrolled in the program each semester until said applicant graduates.

3. I declare under penalty of perjury that these statements are true and correct to the best of my knowledge.

Name (please print)		Title	
Phone/Ex		E-mail	
Date		Signature	

Tape Business Card On All Four Corners
DO NOT STAPLE
BUSINESS CARD REQUIRED

no business card available



Employment History

Please list any work experience that is health related. **List most recent employer first (maximum of 4 employers).** All entries must be filled to be considered complete. If no health related experience, please leave blank. You remain eligible.

1. Employer's Name		Street Address			
City		State, Zip			
County		Supervisor's Name			
Telephone Number		E-mail			
Start Date		End Date or PRESENT			
Your Position/Title		Full Time		Part Time	
		Per Diem		Volunteer	
Description of Duties					

2. Employer's Name		Street Address			
City		State, Zip			
County		Supervisor's Name			
Telephone Number		E-mail			
Start Date		End Date or PRESENT			
Your Position/Title		Full Time		Part Time	
		Per Diem		Volunteer	
Description of Duties					

3. Employer's Name		Street Address			
City		State, Zip			
County		Supervisor's Name			
Telephone Number		E-mail			
Start Date		End Date or PRESENT			
Your Position/Title		Full Time		Part Time	
		Per Diem		Volunteer	
Description of Duties					

4. Employer's Name		Street Address			
City		State, Zip			
County		Supervisor's Name			
Telephone Number		E-mail			
Start Date		End Date or PRESENT			
Your Position/Title		Full Time		Part Time	
		Per Diem		Volunteer	
Description of Duties					



Last Name: _____

First Name: _____

PART F – TWO LETTERS OF RECOMMENDATION

- a. Must be **dated** and **signed** within the last **six (6) months** of the deadline date (March - September 2012).
- b. Must be on letterhead or include the author’s title, name of employer, mailing address, and phone number.
- c. If any of these items are missing from the letter, it will be deemed incomplete and therefore, ineligible.

Please check one:

	My two letters of recommendation comply with the instructions above and are included in my packet.
	My two letters of recommendation comply with the instructions above and will be sent separately by the postmark deadline of September 11, 2011 to: HPE Scholarship Program, 400 R Street, Suite 460, Sacramento, CA 95811

PART G – OFFICIAL TRANSCRIPTS

- a. Must be sealed and marked “Official” by the school(s).
- b. Electronic submission must be sent from the school directly to the Foundation e-mail account: hpef-email@oshpd.ca.gov.
- c. If applicant has attended multiple colleges, all official transcripts must be submitted.

Please check one:

	My official transcripts comply with the instructions above and are included in my packet.
	My official transcripts comply with the instructions above and will be sent separately by the postmark deadline of Sept. 11, 2012, to: HPE Scholarship Program, 400 R Street, Suite 460, Sacramento, CA 95811
	My official transcripts comply with the instructions above and will be emailed to the Foundation’s e-mail by the postmark deadline of Sept. 11, 2012, at hpef-email@oshpd.ca.gov .

PART H – 2011 TAX RETURN AND ALL W-2’S or STUDENT AID REPORT

If submitting a Tax Return read below. If not, go to “f”

- a. Submit a **2011 Federal Tax Return** only (1040, 1040EZ, etc.). (State taxes are NOT acceptable)
- b. You and your spouse’s (if applicable) **signature** must appear on the tax return regardless of who prepared it or how it was filed.
- c. If included on parents’ tax statements, please submit those tax returns.
- d. Include all **W-2’s** or proof of income (1099).
- e. If joint return filed, include both parties’ W-2’s and/or 1099.

If self-employed, check this box (Tax Return are still required.)

If you or joint party do not have W-2’s, check this box and provide an explanation: _____

OR

- f. Submit your 2011-2012 or 2012-2013 **Student Aid Report (SAR)** only from Free Application for Federal Student Aid (FAFSA) www.fafsa.ed.gov
- g. Must show the **expected family contribution (EFC)**
- h. Do not submit FAFSA documents.

Please check one:

	My signed 2011 Federal Tax returns and W-2’s comply with the instructions above and are included in my application packet.
	My signed 2011 Federal Tax returns and W-2’s and/or 1099 comply with the instructions above and will be sent separately by the postmark deadline of Sept. 11, 2012, to: HPE Scholarship Program, 400 R Street, Suite 460, Sacramento, CA 95811.
	My 2011-2012 or 2012-2013 Student Aid Report comply with the instructions above and are included in my application packet.
	My 2011-2012 or 2011-2012 Student Aid Report comply with the instructions above and will be sent separately by the postmark deadline of Sept. 11, 2012, to: HPE Scholarship Program, 400 R Street, Suite 460, Sacramento, CA 95811.



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Last Name: _____

First Name: _____

PART I – COST OF ATTENDANCE/TUITION

a. A copy of the cost of attending the nursing program at your school.

Check when completed:

	I have included the cost of attendance with my application packet.
--	--------------------------------------------------------------------

PART J – CONTACTS

List names, relationship, address, telephone numbers and e-mail of three (3) persons not living with you -- preferably relatives-- that will know how to reach you should the Foundation need to contact you immediately.

1	Name	
Relationship to applicant		
Mailing Address		
Phone		E-mail
2	Name	
Relationship to applicant		
Mailing Address		
Phone		E-mail
3	Name	
Relationship to applicant		
Mailing address		
Phone		E-mail

PERSONAL INFORMATION NOTIFICATION

PERSONAL INFORMATION NOTIFICATION The Information Practices Act of 1977 and the Federal Privacy Act require this program to provide the following to individuals who are asked by the Office of Statewide Health Planning and Development, Health Professions Education Foundation to supply information: The principal purposes for requesting personal information are for verification of identification, establishment of eligibility and program administration. Program regulations (Chapter 14 of Title 22 of the California Code of Regulations, Sections 97701 et seq.) require every individual to furnish appropriate information for application to the Health Professions Education Loan Repayment Program. All requested information is required unless it is specifically identified as voluntary. Failure to furnish this information may result in the return of the application as incomplete. An individual has a right of access to records containing his/her personal information that are maintained by the Office of Statewide Health Planning and Development, Health Professions Education Foundation. The person responsible for maintaining the information is the Executive Director, Health Professions Education Foundation, 400 R Street, Suite 460, Sacramento, CA 95811, (916) 326-3640. The Foundation may charge a small fee to cover the cost of duplicating this information.

***MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS**

Disclosure of your U.S. Social Security Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application will not be processed AND you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.



PART K – INFORMATION RELEASE

I, the undersigned, authorize staff of the Office of Statewide Health Planning and Development/Health Professions Education Foundation (OSHDP/Foundation), to verify my education and employment in connection with the Health Professions Education Scholarship Program. I understand that the information to be provided will include information regarding my employment history and position status. Any information obtained through this release is to be kept confidential by the OSHDP/Foundation. This authorization is valid for five (5) years from the date of this form.

PART L – APPLICATION CERTIFICATION

I certify that all information in this application is true and accurate to the best of my knowledge. I authorize the Health Professions Education Foundation (Foundation) to verify any information submitted as part of this application. I understand that falsification of information contained in this application will disqualify my application and the respective licensing Board will be notified. I understand that if falsification is discovered after I have been awarded or if I breach my contract, I will be required to repay all funds awarded, plus interest and administrative fees. I understand that once submitted, my application and supporting documents become the property of the Foundation. I also understand that my personal statement becomes the property of the Foundation and may be used, including but not limited to, advertising/marketing, program reports, newsletters, and other publications.

By signing this application, I acknowledge that I understand, if awarded the scholarship, I will agree to the below terms:

- ✓ attend a mandatory scholarship contract orientation call
- ✓ return all correspondence in a timely manner
- ✓ maintain a GPA of at least 2.0
- ✓ be enrolled in a minimum of 6 units
- ✓ become licensed in California
- ✓ fulfill a two-year service obligation at a qualified facility
- ✓ repay all funds received if I do not comply with the contract

Last Name: _____ First Name: _____ MI: _____

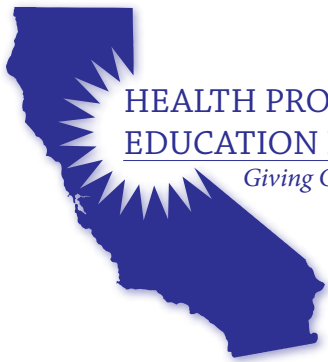
Applicant's Signature: _____ Date: _____



If you do not SIGN and DATE your application, it will be considered INCOMPLETE and INELIGIBLE. Send this ORIGINAL SIGNED AND DATED PAGE. Electronic signatures are NOT acceptable. No copies or faxes will be accepted.

Submit applications to:
Health Professions Education Foundation
ATTN: HPE Scholarship Program
400 R Street, Suite 460
Sacramento, CA 95811
(800) 773-1669 or (916) 326-3640

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**HEALTH PROFESSIONS
EDUCATION FOUNDATION**

Giving Golden Opportunities

400 R Street, Suite 460
Sacramento, CA 95814
www.healthprofessions.ca.gov
(800)773-1669



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