



HEALTH PROFESSIONS
EDUCATION FOUNDATION

Giving Golden Opportunities



Health Professions Education Scholarship & Loan Repayment Application



Spring Postmark Deadline: March 24, 2009

*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*



Application Instructions



If you want receipt confirmation of your application packet, please submit one self-addressed stamped envelope with your application.

You must be a California resident and a citizen or permanent resident of the U.S. to apply.

The Health Professions Education Program offers two types of awards: the Health Professions Education Scholarship and the Health Professions Education Loan Repayment. The purpose of these awards is to increase the number of health professionals practicing in medically underserved areas of California. Applications for the Health Professions Education Program are accepted annually in March.

Any monies awarded under this program are intended to pay or repay tuition, required fees, books, supplies, and educational equipment costs related to the applicants health professional education. All awards are subject to the availability of funding.

Recipients will be required to sign a written contract with the Foundation outlining the provisions which must be met to fulfill the obligations under this program. Failure to comply with the terms of the contract may result in the awardee's repayment of the funds awarded plus interest.

SELECTION CRITERIA

Selection for the Health Professions Education Scholarship and Loan Repayment Programs is based solely on information contained in the application and supporting documentation. Selection for awards is based on the following criteria:

Work Experience - nursing and non-nursing work experience in a medically underserved area (MUA).

Financial Need - actual or potential difficulty in completing education in the absence of an award.

Career Goals - professional goals for the next five (5) to ten (10) years.

Community Service - documented volunteer service and/or activities, particularly in a MUA.

Community Background - family structure economic background and community where applicant grew up; for example, rural, inner city/urban, suburban, or MUA.

Academic Performance - prior and current academic performance; potential for future academic success.

Priority will be given to: Individuals whose community background and commitment indicates the likelihood of long-term employment in a MUA even after the service obligation has ended.

Awards are made on a competitive basis. Each part of the application must be completed. All supporting documentation must be submitted by the appropriate deadline. Only complete applications will be evaluated. The Foundation will not notify individuals if their application is incomplete.

SCHOLARSHIP Eligibility

Students may receive up to **\$10,000** for the **Health Professions Education Scholarship**. Scholarships are funded for one (1) academic year, generally two (2) semesters or three (3) quarters.

Scholarship Eligibility - Scholarships are available to students who are enrolled or accepted in a Health Professions program. Awardees must sign a contract with the Office of Statewide Health Planning and Development (OSHDP)/Health Professions Education Foundation (Foundation) and agree to the following terms:

Be enrolled or accepted to one of the following health professional

education programs: dentistry, dental hygiene, nurse practitioner, physician assistant, or certified nurse midwifery.

Complete a two (2)-year service obligation to practice your profession in a MUA of California providing direct patient care on a full-time basis (minimum of 32 hours per week).

Be a full-time or part-time student (no less than six (6) units) in a California accredited school.

Maintain a minimum cumulative GPA of 2.0 each year scholarship funds are sought.

SUBMIT THE FOLLOWING

1. Completed Application

Complete all pages of this application. It must be completed, signed, and dated to be considered eligible.

2. Official Transcript(s) Related To Your Health Professional Education

If you are a student in your first year of the health professional program and your transcripts do not reflect your education, submit your most current transcript. The transcript(s) must be marked official by the school and delivered to the Foundation in a sealed envelope. The Foundation will not accept unofficial transcripts, copies or print outs of transcripts, or transcripts in an open/unsealed envelope.

3. Personal Statement (Part E of the Application)

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

4. Two Professional Letters of Recommendation

Letters of recommendation must be dated within six (6) months of the application deadline. 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. To receive maximum credit for community service a letter from the agency where service was provided must be submitted.

5. Graduation Date Verification Form

This form must be signed by the nursing program director or a faculty member authorized to sign on the director's behalf. The Graduation Date Verification Form is enclosed as part of the scholarship application. Applicants can also download this form from the Foundation's Web site at www.healthprofessions.ca.gov.

6. Student Aid Report (SAR)

Students must submit the final 2009-2010 SAR. The SAR must indicate the student's expected family contribution (EFC). The FAFSA is available from all college financial aid offices and is also available on the Internet at www.ed.gov/offices/OPE/express.html. **DO NOT SUBMIT FAFSA.**

OR

Signed 2008 Federal Tax Return and all W-2s - Applicants who do not apply for financial aid must submit a complete copy of their 2008 Federal Tax

Application Instructions (cont.)



Return and all W-2s. **DO NOT SEND YOUR STATE TAX RETURN.**

7. Linguistic Competency

Fluency in a second language must be verified on the Employment or Graduation form or in a letter of recommendation from employer or school faculty.

LOAN REPAYMENT AWARDS

The **Health Professions Loan Repayment Program** repays up to **\$20,000** in educational debt that was incurred while attending a health professional program. In return for the loan repayment, the awardee must agree to practice direct patient care in a MUA for a minimum of two (2) years.

Loan Repayment Eligibility - Loan repayment awards are available to licensed health professionals, who are currently practicing in a MUA. If you have any questions about whether your facility qualifies as a MUA, please contact the Foundation at (800) 773-1669. Awardees must sign a contract with the OSHPD/Foundation and agree to the following terms:

Be a graduate of one of the following health professional education programs: dentistry, dental hygiene, nurse practitioner, physician assistant, or certified nurse midwifery.

Complete a 2-year service obligation to practice your profession in a MUA of California providing direct patient care. While completing the service obligation, **work full-time or work a minimum of 32 hours per week.**

Be a currently licensed health professional.

SUBMIT THE FOLLOWING

1. Completed Application

Complete all pages of this application. It must be completed, signed, and dated to be considered eligible.

2. Official Transcript with your health professional degree posted

The transcript must be marked official by the school and delivered to the Foundation in a sealed envelope. If the school does not release official transcripts to the student, the transcript may be sent directly from the school to the Foundation. The Foundation will not accept unofficial transcripts, copies or print outs of transcripts, or transcripts in an open/unsealed envelope.

Your health professional degree must be posted on the transcript unless you are a student in the final year in a course of study leading to a health professional degree. If you are in the final year of the program, submit the most current transcript(s) that illustrate your health professional education to date.

3. Personal Statement (Part E of the Application)

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

4. Two Professional Letters of Recommendation Letters of recommendation must be dated within six (6) months of the application deadline. 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. To receive maximum credit

for community service a letter from the agency where service was provided must be submitted.

5. Employment Verification Form (EVF)

This form must be **signed** by an official in your department. The EVF is enclosed as part of this application. Applicants can also download this form from the Foundation's Web site at www.healthprofessions.ca.gov.

6. 2008 Federal Tax Return and all W-2s

DO NOT SUBMIT A STATE TAX RETURN. The State Tax Return will not be accepted in lieu of the Federal Tax Return.

7. Educational Debt Reporting Form

Submit the attached educational debt reporting form and copies of your most recent lender statements (dated within six (6) months) with your name, the name of lender, balance owing, account number, and monthly payments. All information must be filled in or the application will be considered incomplete.

8. Linguistic Competency

Fluency in a second language must be verified on the Employment or Graduation form from employer or school faculty.

INELIGIBILITY

Applicants who owe a service obligation to practice direct patient care to another entity entered into before filing an application with the Foundation are ineligible to receive a scholarship. Previous obligations must be completed before applying. Awardees who breach their contract with the OSHPD will not be allowed to reapply for additional awards.

APPLICATION SUBMISSION

Applications must be postmarked by the deadline. In order to be eligible, each part of the application must be completed. All supporting documentation must be submitted. The Foundation will not notify applicants if their application is received incomplete. Applicants are urged to contact the Foundation at (800) 773-1669 prior to the final filing date to verify if their application was received complete. Do not bind or submit applications in a loose-leaf binder.

NOTIFICATION OF AWARDS

The Foundation will notify applicants of their application results within 120 days of the postmark deadline.

SPRING POSTMARK DEADLINE: MARCH 24, 2009

Submit applications to:

**Health Professions Education Foundation
Health Professions Education Program
400 R Street, Suite 460
Sacramento, CA 95811
(800) 773-1669 or (916) 326-3643**

Application

Last Name

First Name



Please refer to the application instructions when completing the application. Complete all pages of the application form, and make sure all supporting documents are submitted with your application. All documents must be postmarked by the application deadline. Late or incomplete application packets will not be evaluated.

Which program are you applying for? **Scholarship (up to \$10,000)** **Loan Repayment (up to \$20,000)**

Please enter the award amount you are requesting: _____

PART A - PERSONAL INFORMATION

Applicants may apply for only one award using this application (Please type or print your answers legibly in the space provided).

Mr. Mrs. Ms. Dr.	Last Name:		First Name:		Middle Initial:
CA Drivers License Number:			*Social Security Number:		
Mailing Address:					
City:		State:		Zip:	
County:					
Permanent Address (if different than above):					
City:		State:		Zip:	
County:					
Home Phone: ()			Date of Birth:		
Cell Phone: ()			E-mail Address:		
Work Phone: ()			Gender: Male Female	Marital Status (Optional): Unmarried Married	
Are you a citizen or permanent resident of the U.S.? Yes No			Are you a California resident? Yes No		
Number of dependents other than self and spouse (as declared on tax returns or student aid report):					
Which best describes your ethnic background:					
African American		Caucasian		Native American	
Asian American		Hispanic/Latino		Pacific Islander	
Other (Please specify) _____					
If Native American, please specify tribal affiliation and submit verification: _____					

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 16 of Title 22 of the California Code of Regulations, Sections 97900 et seq.) require every individual to furnish appropriate information for application to the Licensed Mental Health Service Provider Education 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 Program Director, Health Professions Education Foundation, 400 R Street, 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.

FOR OFFICIAL USE ONLY

Recd:	Compl / Inc:	Omitted: App Pgs	GDV	EVF	SAR	TAX	LoR	Other
App Inquiry: (- -) (- -)	HPEF Contact:		for:					
Input By:	MUA: Yes / No	CT#:						
Reviewed By:	Comments:							

Applicant's Name: _____



PART B – WORK EXPERIENCE

1. Are you currently employed as a licensed healthcare provider?
Yes No

If yes, provide license # _____

Expiration Date: ___/___/___

PART C – COMMUNITY BACKGROUND

Have you lived in an economically disadvantaged background (income below the federal poverty level, low income, subsidized income, qualified for public program, lived in rural, inner city or medically underserved area) for at least two years?

Yes No

If yes, please check the appropriate range of years.

2-5 years 6-10 years 11 or more years

PART D – LINGUISTIC COMPETENCY

1. List any languages in which you are fluent. This must also be verified by the applicant's employer on the Employment Verification or Certification of Enrollment Form.

1st language: _____

2nd language: _____

3rd language: _____

PART E – PROGRAM OF STUDY

Check which of the following health professional programs you are a student or graduate of:

Dentistry
Physician Assistant
Certified Nurse Midwifery

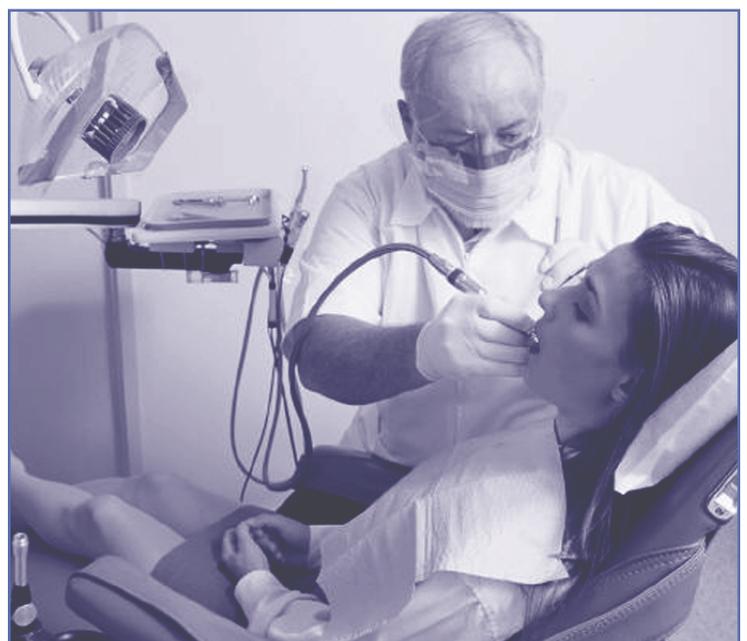
Nurse Practitioner
Dental Hygiene

PART F – 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.

**Scholarship applicants must answer questions 1-6.
Loan Repayment applicants must answer questions 2-6.**

1. What kind of work would you like to do immediately after graduation?
2. What kind of work do you think you'll be doing in five years?
3. What are your professional goals for the next five (5) to ten (10) years, as they relate to a health profession?
4. Describe any community service, volunteer activities, or club memberships within the past two years (**Please attach any letters of recommendation you may have. Do not include experience for which you received academic credit.**)
5. Describe your family background including your parent or guardian's occupation, marital status, family size such as number of dependents including yourself, where you were raised, first in family to attend college, English as a second language and any other factors that help describe your family's socio-economic situation.
6. Describe how your background is relevant to your interest in pursuing a nursing career. Do you see your background as an advantage, disadvantage, or both?



Applicant's Name: _____

PART G – QUESTIONNAIRE

Do you currently owe a service obligation to another entity?
Yes No

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

Are you a previous awardee of the Foundation? Yes No

If yes, please enter the contract # _____

Are you the first in your family to attend college? (optional) Yes No

Where did you hear about the Health Professions Education Program?

(Check all that apply)

Work (employer or co-worker)	Friend/Acquaintance	
TV	Radio	Foundation website
Other website	Advertisement	
Newspaper or publication (please specify) _____		
Organization or Affiliation (please specify) _____		
Other source (please specify) _____		

Where did you receive the Health Professions Education Program application? (Check only one)

Program Director/Instructor	Foundation office
Foundation website	Other website
Work (employer/co-worker)	Friend/Acquaintance
Other (please specify) _____	



PART H – APPLICATION CERTIFICATION

I certify that all information in this application is true and accurate to the best of my knowledge. I authorize the 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.

Name (please print)

Last Name: _____

First Name: _____ Middle Initial: _____

Applicant's Signature: _____

Date: _____

SCHOLARSHIP CHECKLIST

1. Completed Application
2. Official Transcript(s) related to your health professions education
3. Personal Statement
4. Two (2) Professional Letters of Recommendation
5. Graduation Date Verification Form
6. 2009/2010 Student Aid Report or 2008 Federal Tax Return and all W-2s

LOAN REPAYMENT CHECKLIST

1. Completed Application
2. Official Transcript(s) with health professions degree posted
3. Personal Statement
4. Two (2) Professional Letters of Recommendation
5. Employment Verification Form
6. 2008 Federal Tax Return and all W-2s
7. Educational Debt Reporting Form and Lender Statements

Work History

➤ Please list all work experiences. **List most recent employer first** (maximum of 4 employers).

Employer's Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
County: _____
Supervisor's Name: _____
Telephone Number: _____
Your Position/Title: _____ Monthly Salary: _____

Full-time OR Part-time

Employment Start Date: ____/____/____
Employment End Date: ____/____/____
Average hours worked (please choose only one):
_____/day ____/week ____/month

Brief description of your job duties: _____

Employer's Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
County: _____
Supervisor's Name: _____
Telephone Number: _____
Your Position/Title: _____ Monthly Salary: _____

Full-time OR Part-time

Employment Start Date: ____/____/____
Employment End Date: ____/____/____
Average hours worked (please choose only one):
_____/day ____/week ____/month

Brief description of your job duties: _____

Employer's Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
County: _____
Supervisor's Name: _____
Telephone Number: _____
Your Position/Title: _____ Monthly Salary: _____

Full-time OR Part-time

Employment Start Date: ____/____/____
Employment End Date: ____/____/____
Average hours worked (please choose only one):
_____/day ____/week ____/month

Brief description of your job duties: _____

Employer's Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
County: _____
Supervisor's Name: _____
Telephone Number: _____
Your Position/Title: _____ Monthly Salary: _____

Full-time OR Part-time

Employment Start Date: ____/____/____
Employment End Date: ____/____/____
Average hours worked (please choose only one):
_____/day ____/week ____/month

Brief description of your job duties: _____

Graduation Date Verification Form

(For Scholarship Applicants Only)

ATTENTION! The completed form must bear an original ink signature. Photocopies and faxed copies of the completed form are not acceptable.

FORM TO BE COMPLETED BY THE PROGRAM DIRECTOR OR AN APPROPRIATE DESIGNEE
(The person signing this form may not be related to the applicant by blood, marriage, or adoption)

Student's Last Name: _____ First Name: _____ Middle Initial: _____

School Name: _____

Program Enrolled: _____

School Mailing Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Year Entered (Month / Year): _____ Expected Graduation Date (Month / Year): _____

Enrollment Status: F/T or P/T # of units currently enrolled: _____

Current GPA: _____ or # of units equivalent if on a modular system: _____

Please comment on the student's performance and potential for academic success.

Please attach a copy of any record showing the tuition costs for the program the student is enrolled or accepted in.

Through our selection process, I have determined that the applicant can speak the following language(s):

1st language: _____

2nd language: _____

3rd language: _____

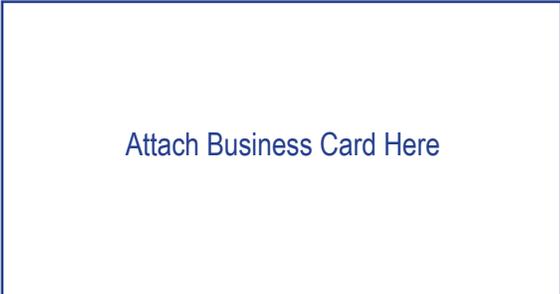
Name: (Please Print) _____

Signature: _____

Title: _____

Phone Number: _____

Fax Number: _____



Employment Verification Form

(For Loan Repayment Applicants Only)

**ATTENTION! The completed form must bear an original ink signature.
Photocopies and faxed copies of the completed form are not acceptable.**

FORM TO BE COMPLETED BY AN OFFICIAL IN THE PERSONNEL OR HUMAN RESOURCES DEPARTMENT
(The person signing this form may not be related to the applicant by blood, marriage, or adoption)

Employee's Last Name: _____ First Name: _____ Middle Initial: _____

Job Title: _____

Average Monthly Hours Worked _____ F/T or P/T Start Date: ____/____/____

Facility Name: _____

Address (NO P.O. BOXES): _____

City: _____ State: _____ Zip Code: _____

County: _____

Through our selection process, I have determined that the applicant can speak the following language(s):

1st language: _____

2nd language: _____

3rd language: _____

I declare under penalty of perjury that these statements are true and correct.

Name: (Please Print) _____

Signature: _____

Title: _____

Phone Number: _____

Fax Number: _____

Email: _____

Date: _____

Attach Business Card Here

Educational Debt Reporting Form

- List source and amounts of outstanding educational loans used to finance your education below.
- You must submit current lender statements (dated within 6 months) of the educational debts listed below. They should include the current balance, account number, your name, and address to which payment is submitted. **In the case of loan consolidation, please include proof of the original loan sources.**

All spaces must be completed. If payments are deferred an amount must be entered into the monthly payment space.
If any information is missing the application will be considered incomplete.

LOAN 1

School Attended: _____ Loan Period (Start Date): ___/___/___ (End Date): ___/___/___

Loan Program: _____ Loan ID#: _____ Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip Code: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____

LOAN 2

School Attended: _____ Loan Period (Start Date): ___/___/___ (End Date): ___/___/___

Loan Program: _____ Loan ID#: _____ Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip Code: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____

LOAN 3

School Attended: _____ Loan Period (Start Date): ___/___/___ (End Date): ___/___/___

Loan Program: _____ Loan ID#: _____ Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip Code: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____

LOAN 4

School Attended: _____ Loan Period (Start Date): ___/___/___ (End Date): ___/___/___

Loan Program: _____ Loan ID#: _____ Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip Code: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____



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