

Vocational Nurse Scholarship

Licensed Vocational Nurse to Associate Degree Nursing Scholarship

Licensed Vocational Nurse Loan Repayment Program Application

Partial program funding provided by grants from
The California Wellness Foundation and
S. Mark Taper Foundation

*Giving Golden
Opportunities by:*

*Increasing the supply of
licensed vocational nurses practicing in
underserved areas*

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

*Helping students to pursue a
career in the health professions*

*Awarding nurses 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 application.

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

The purpose of the Vocational Nurse (VN) Scholarship, Licensed Vocational Nurse to Associate Degree Nursing (LVN to ADN) Scholarship, and Licensed Vocational Nurse Loan Repayment (LVNLRP) programs are to increase the number of vocational nurses practicing in medically underserved areas (MUA) of California and to assist LVNs in pursuing their Associate Degree in Nursing (ADN).

Applications for the VN Scholarship, LVN to ADN Scholarship, and LVNLRP programs are accepted biannually. Monies awarded under this program are intended to pay or repay tuition, required fees, books, supplies, and educational equipment costs related to the applicant's nursing education. All awards are subject to the availability of funding.

SELECTION CRITERIA

Selection for the VN Scholarship, LVN to ADN, and LVNLRP programs are 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 to ten years.

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

Community Background - community where applicant grew up.

Academic Performance - prior and current academic performance.

Priority will be given to: Applicants whose community background and commitment indicates the likelihood of long-term employment in a medically underserved area 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. Only complete applications will be evaluated. The Health Professions Education Foundation (Foundation) will not notify individuals if their application is incomplete.

VOCATIONAL SCHOLARSHIPS

Students may receive up to **\$4,000** for the **VN Scholarship**. Scholarships are funded for one academic year, usually 2 semesters or 3 quarters. Graduation dates may impact the amount of funding you are eligible to receive.

Scholarship Eligibility - Scholarships are available to students who are enrolled or accepted in an accredited **VN Program**. Awardees must sign a **contract** with the Office of Statewide Health Planning and Development (OSHPD) and agree to the following terms:

Complete a 2-year service obligation to practice in a MUA of California as a LVN providing direct patient care **full-time or a minimum of 32 hours per week**.

Be a full-time or part-time student (no less than 6.0 units) in a California accredited school.

Maintain a minimum cumulative GPA of 2.0 or grade average of C or better each year scholarship funds are sought.

LVN TO ADN SCHOLARSHIP

Students may receive up to **\$8,000** for the **LVN to ADN** Scholarships are funded for one academic year, usually 2 semesters or 3 quarters. Your graduation date may impact the amount of funding you are eligible to receive.

Scholarship Eligibility - Scholarships are available to LVN students who are enrolled or accepted in an accredited **ADN Program**. Priority will be given to students who will be graduating within 1 to 2 years. Awardees must sign a contract with the OSHPD and agree to the following terms:

An LVN applicant who is eligible to apply for the **Registered Nurse Education Program (RNEP)** must first apply for that program, and if rejected, will then be considered eligible to apply for the LVN to ADN Scholarship. Applications for the LVN to ADN scholarship must be made within 12 months of rejection from the RNEP.

Complete a 2-year service obligation to practice in a MUA of California as a RN providing direct patient care **full-time or a minimum of 32 hours per week**.

Be a full-time or part-time student (no less than 6.0 units) in a California accredited school.

Maintain a minimum cumulative GPA of 2.0 or grade average of C or better each year scholarship funds are sought.

Be a LVN with a current and active California license and be in good standing with the Board of Vocational Nursing and Psychiatric Technicians (BVNPT).

Upon completion of ADN must provide official transcripts to Foundation

Application Instructions (cont.)



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)

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 D of 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.

4. Two Professional Letters of Recommendation

Letters of recommendation must be dated within six 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. Program Completion 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 Program Completion 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. Verification of Language Fluency, if applicable

Fluency in a Medi-Cal threshold language must be verified on the Employment or Program Completion Form or in a letter of recommendation from employer or school facility.

7. Student Aid Report (SAR)

Students must submit the final 2008-2009 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

2007 Federal Tax Return and all W-2s - Applicants who do not apply for financial aid must submit a complete copy of their 2007 Federal Tax Return with all W-2s. **DO NOT SEND STATE TAX RETURN.**

LOAN REPAYMENT AWARDS

The **LVN Loan Repayment Program** repays up to **\$6,000** in educational debt that was incurred while attending an accredited VN program.

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

Complete a 2-year service obligation to practice in a MUA of California as a LVN providing direct patient care. While completing the service obligation, **work full-time or work a minimum of 32 hours per 5 day period or work week.**

Be a LVN with a current and active California license and be in good standing with the BVNPT.

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 LVN Certification of Program Completion

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 LVN Certification of Program Completion must be posted on the transcript unless you are a student in the final year in a course of study leading to a LVN Certification of Program Completion. If you are in the final year of the VN program, submit the most current transcript(s) that illustrate your VN education to date.

3. Personal Statement (Part D of 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.

4. Two Professional Letters of Recommendation

Letters of recommendation must be dated within six 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.

Application Instructions (cont.)



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. Proof of current and active California VN license and be in good standing with the BVNPT.

7. Verification of Language Fluency, if applicable

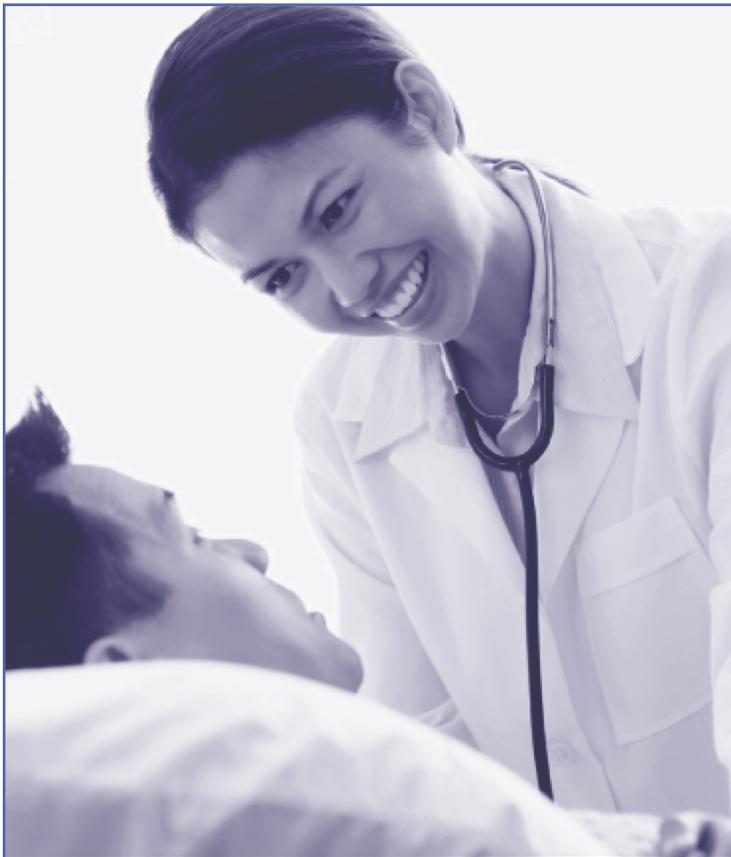
Fluency in a Medi-Cal threshold language must be verified on the Employment Verification Form or in a letter of recommendation from employer or school faculty.

8. 2007 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.

9. Educational Debt Reporting Form

Submit the attached educational debt reporting form and copies of your most recent lender statements (within 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.



INELIGIBILITY FOR VN AWARDS

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/HPEF 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 eight weeks of the postmark deadline.



SPRING POSTMARK DEADLINE: MARCH 24, 2008
FALL POSTMARK DEADLINE: SEPTEMBER 11, 2008

Submit applications to:

Health Professions Education Foundation
VN Scholarship, LVN to ADN Scholarship, & LVN
Loan Repayment Programs
400 R Street, Suite 330
Sacramento, CA 95811
(800) 773-1669 or (916) 326-3640

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.

Do you owe an existing service obligation to another entity? Yes No

Which program are you applying for? VN Scholarship (\$4,000) LVN Loan Repayment (\$6,000) LVN to ADN Scholarship (\$8,000)

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).

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		Name (last, first, 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status (Optional): <input type="checkbox"/> Unmarried <input type="checkbox"/> Married
Are you a citizen or permanent resident of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a California resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of dependents other than self and spouse (as declared on tax returns or student aid report):			
Which best describes your ethnic background:			
<input type="checkbox"/> African American		<input type="checkbox"/> Caucasian	<input type="checkbox"/> Native American
<input type="checkbox"/> Asian American		<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Pacific Islander
<input type="checkbox"/> Other (Please specify) _____			

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 an LVN? Yes No
If yes, provide license # _____ Expiration Date: ___/___/___

PART C – COMMUNITY & LANGUAGE BACKGROUND

1. Check any Medi-Cal threshold languages that you are fluent in. Please submit verification (see Verification of Language Fluency in the instructions).

- | | | |
|------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Hmong | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Armenian | <input type="checkbox"/> Korean | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Other Chinese | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Farsi | | |

2. Have you lived in an economically disadvantaged background (i.e. low income or subsidized income from local, county, state, and/or federal agencies) in California for at least two (2) years? Yes No

If yes, please check the appropriate range of years.

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

PART D – 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.

ALL Scholarship applicants must answer questions 1-7.

LVN Loan Repayment applicants must answer questions 2-7.

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 is your vision of your professional future in ten years?
4. Describe any community service, volunteer activities, or club memberships within the past two years (**Please include any letters of recommendation you may have with your application packet. Do not include experience for which you received academic credit.**)
5. Describe your family background including: your father's and mother's occupation, socioeconomic status, marital status, and number of dependents including yourself.
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?
7. Please add any other information you believe is relevant, i.e. certificates/awards.



Applicant's Name: _____



PART E – QUESTIONNAIRE

Are you a previous awardee of the Foundation? Yes No

If yes, please enter the contract # _____

Have you applied to and been rejected from receiving funds from the Registered Nurse Education Program (RNEP)? Yes No

If yes, please attach a copy of the rejection letter.

If no, please apply for the RNEP.

Where did you hear about the Health Professions Education Program?

(Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Work (employer or co-worker) | <input type="checkbox"/> Friend/Acquaintance |
| <input type="checkbox"/> TV | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Other Web site | <input type="checkbox"/> Foundation Web site |
| <input type="checkbox"/> Newspaper or publication (please specify) _____ | <input type="checkbox"/> Advertisement |
| <input type="checkbox"/> Organization or Affiliation (please specify) _____ | |
| <input type="checkbox"/> Other source (please specify) _____ | |

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

- | | |
|---|--|
| <input type="checkbox"/> Program Director/Instructor | <input type="checkbox"/> Foundation office |
| <input type="checkbox"/> Foundation Web site | <input type="checkbox"/> Other Web site |
| <input type="checkbox"/> Work (employer/co-worker) | <input type="checkbox"/> Friend/Acquaintance |
| <input type="checkbox"/> Other (please specify) _____ | |

PART F – 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 BVNPT 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 rights 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)
- 3. Personal Statement
- 4. Two (2) Professional Letters of Recommendation
- 5. Program Completion Verification Form
- 6. 2008/2009 Student Aid Report or 2007 Federal Tax Return and all W-2s
- 7. Copy of the cost of attendance/tuition for VN program.

LOAN REPAYMENT CHECKLIST

- 1. Completed Application
- 2. Official Transcript(s) with LVN Certificate of Program Completion posted
- 3. Personal Statement
- 4. Two (2) Professional Letters of Recommendation
- 5. Employment Verification Form
- 6. Proof of current and active California VN license and be in good standing with the BVNPT
- 7. 2007 Federal Tax Return and all W-2s
- 8. Educational Debt Reporting Form and Lender Statements

Work History



➤ Please list all work experience you have had. **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: _____

Program Completion Verification Form

(For Scholarship Applicants Only)



➤ **Must be completed by the Program Director or his/her designee.**

The student named below is applying for a scholarship from the Health Professions Education Foundation. This form is required for the application to be considered complete. The form must be returned to the Foundation with an original signature.

Applicant's Name: _____

School Name: _____

Program Enrolled: _____

School Mailing Address: _____

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

Year Entered: _____ Expected Program Completion Date: _____
Month/Year Month/Year

Enrollment Status: F/T P/T # of units currently enrolled: _____ GPA: _____
(Based on FALL or SPRING Semester/ Quarter academic year) (as defined by the educational institution)

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 VN program the student is enrolled or accepted in.

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

- | | | | |
|------------------------------------|---------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Farsi | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Armenian | <input type="checkbox"/> Hmong | <input type="checkbox"/> Other Chinese | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Korean | <input type="checkbox"/> Russian | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Cantonese | | | |

- I certify that I am the Program Director.
 I certify that I am authorized to sign this document on behalf of the Program Director.

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

Name: (Please Print) _____

Signature: _____

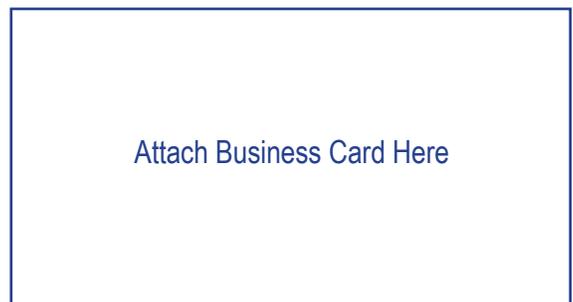
Title: _____

Phone Number: _____

Fax Number: _____

Email: _____

Date: _____



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 Name: _____

Job Title: _____

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

Employee's Supervisor: _____

Title: _____ Telephone Number: _____

Employer: _____

Employer's Address (NO P.O. BOXES): _____

City: _____ State: _____ Zip Code: _____

County: _____

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

- | | | | |
|------------------------------------|---------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Farsi | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Armenian | <input type="checkbox"/> Hmong | <input type="checkbox"/> Other Chinese | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Korean | <input type="checkbox"/> Russian | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Cantonese | | | |

- I certify that I am the Program Director.
 I certify that I am authorized to sign this document on behalf of the Program Director.

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

Name: (Please Print) _____

Signature: _____

Title: _____

Phone Number: _____

Fax Number: _____

Email: _____

Date: _____



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.**

For Loan Repayment Applicants Only. 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: _____

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: _____

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: _____

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

LOAN 4

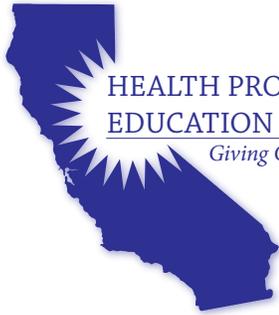
School Attended: _____ Loan Period (Start Date): ___/___/___ (End Date): ___/___/___

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

Lender's Address: _____

City: _____ State: _____ Zip: _____

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



**HEALTH PROFESSIONS
EDUCATION FOUNDATION**

Giving Golden Opportunities

400 R Street, Suite 330
Sacramento, CA 95811
www.healthprofessions.ca.gov
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