APPLICANT INFORMATION

Application will not be considered if all blanks are not completed.

Have you received assistance through the Oklahoma Nursing Student Assistance Program in the past? Yes ☐ No ☐

If yes, what years was it received?

OFFICE USE ONLY: Fulfilled ❑

Check the type for which you are applying: ☐ Non-Matching ☐ Matching (Sponsor must complete the Sponsor section on the back page of Matching applications. Only one application and sponsor per applicant.)

Name _____
Last First Middle (Maiden if applicable)

Date of Birth (Required) _____ Social Security Number _____

Permanent Address (where mail will always reach you) _____

City, State _____ Zip+4 (**Use 9-digit zip code**) _____ County _____

Address this July _____

Cell Phone (_____) _____ Second Phone (_____) _____ E-Mail: _____

List dates lived in Oklahoma _____ Are you a U.S. Citizen*? Yes _____ No _____
(***Must be a U.S. Citizen in order to apply**.)

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Name of Spouse _____ Spouse Social Security Number _____
Must be entered even if separated.

Spouse Occupation _____ Spouse Employer _____

Number of Dependents other than yourself and spouse _____ Ages: _____ _____ _____ _____ _____ _____ _____

Do dependents live in your household? Yes _____ No _____ If no, explain _____

Are you currently licensed to practice as a LPN or RN in Oklahoma? Yes ☐ No ☐ Current License Number _____

Are you or have you ever worked in a health-related occupation? Yes ☐ No ☐ If so, how long? _____

Where and in what capacity? _____

Present Employer and Address _____

STUDY PLANS

Check semester(s)you will be enrolled in nursing program: ☐ Fall 20_____ ☐ Spring 20_____

University, college, or technical school where you have been admitted into the nursing program:

_____ | _____ Date you expect to receive your degree: _____
Institution Name City & State Month / Year

Program of Study: LPN☐ ADN☐ BSN☐ MSN☐ MSN-NP☐ MSN-Educ☐ List intended dates of study in nursing program. From _____ To _____
Month/Year Month/Year

***Masters of Nursing Adm/Leadership does NOT qualify.**

If LPN program, please indicate: Two-Year ☐ One-Year ☐ Self-Pace ☐

If career ladder BSN program, indicate when nursing course work will be complete _____ and when graduating and receiving BSN _____
Month/Year Month/Year

When do classes begin for the next academic year? _____ Estimate intended number of credit hours for Fall, 20_____ Spring, 20_____

Do you plan to work while attending school? Yes ☐ No ☐ If yes, how many hours per week? _____

What are your professional goals? _____

_____

Many people apply for this scholarship loan. Please give reasons you feel you should be selected. _____

_____

_____

In what community do you plan to practice nursing? _____

If applying for a matching scholarship, are you related to the owner or an employee of the sponsoring institution? Yes _____ No _____

If yes, please give name and relationship. _____

Have you read a copy of the contract you will be asked to sign if you are awarded a scholarship loan? Yes _____ No _____ (Sample available on our website.)

Get answers to frequently asked questions at: www.**pmtc.ok.gov/nsap.htm**.

FINANCIAL INFORMATION

Application not accepted without completion.

Available Income	Actual for Last Year Calculate and enter annual amounts.	Estimated for This Year Calculate and enter annual amounts.
Applicant's Personal Income		
Spouse Income		
Parental Support		
Alimony		
Child Support		
School Financial Aid		
Welfare Benefits: (AFDC, Food Stamps, TANF, Subsidized housing, etc.)		
Social Security Benefits		
Other Income		
Enter Annual Totals	Total Received	Estimated Total

Are you currently, or will you be receiving assistance from any of the following? **ENTER FINANCIAL AMOUNTS ABOVE.**

Stafford	_____	Pell Grant	_____	Vocational Rehabilitation	_____
OTAG	_____	Perkins	_____	Low Income Housing	_____
SEOG	_____	Food Stamps	_____	BIA Grant or Indian Health	_____
WIA	_____	Welfare or AFDC	_____	Other (name source)	_____

Will any family member living in your household, other than yourself, be enrolled in college? Yes ☐ No ☐ How many?

Have you received or applied for other assistance with a work obligation? Yes ☐ No ☐ Please explain: _____

Estimated cost of attendance: Tuition and Fees $ _____ Uniforms and Supplies $ _____

Books $_____ Transportation $_____ Total commuting miles per week: _____

Where will you live during the school year? With Parents ☐ On Campus ☐ Off Campus ☐

Are you currently in default or delinquent in payment on a student loan? Yes ☐ No ☐

Have you ever been convicted of a felony? Yes ☐ No ☐

APPLICANT'S STATEMENT

Read & Initial

1. I am applying for financial assistance as an incentive to complete my education in nursing and to provide professional services in a health/sickness care institution, state agency or educational institution in Oklahoma. 1. _____

2. **Matching Scholarship Program.** I understand that the receipt of loan funds requires a full-time practice obligation of one year with the sponsor as specified in this application for each year of financial support received (with a minimum of one year) or repayment of scholarship funds plus interest and/or liquidated damages. 2. _____

   Non-Matching Scholarship Program. I understand that the receipt of loan funds requires a full-time practice obligation of one year in the State of Oklahoma for each year of financial support received (with a minimum of one year) or repayment of scholarship funds plus interest and/or liquidated damages. _____

3. To qualify as a legal resident for the purpose of this program, a person must have maintained his/her domicile in Oklahoma for at least one year immediately prior to a request for funds and qualify for resident tuition. If the applicant is under eighteen, or dependent, the status of the domicile is determined by that of his/her parents or legal guardian. 3. _____

CHECK ALL THAT APPLY.

_____ I am twenty-three years of age or older.

_____ I am eighteen years of age or older.

_____ I am a legal resident of Oklahoma.

_____ I would qualify for residency based on the residency status of my parents or legal guardian.

4. The Physician Manpower Training Commission (PMTC) is given permission to contact any parties or to obtain the sources of information, which it deems necessary to verify my eligibility for a loan. I consent for my nursing school to release my grades or my status in school upon request of the PMTC. I consent for verification of my work obligation upon request of the PMTC. 4. _____

   The information given in this application and supporting forms is accurate and true to the best of my knowledge. I understand that if I knowingly make a false statement or misrepresentation on this application or any of the required supporting documents, it will be grounds for termination of the loan, immediate repayment of any funds already paid to me, and possible criminal action.

_____ _____

Date **Applicant Signature**

Application must be completed on back page. ! **APPLY EARLY!!**

REFERENCES

Relative:

Name

Relationship

Address

City, State, Zip

Phone Number

Non-Relative:

Name of non-relative

Relationship

Address

City, State, Zip

Phone Number

SPONSOR SECTION

Nursing Student Assistance Program

In order for the application to be processed as matching, the sponsoring institution must complete this section.
The applicant's required supporting documents must be attached for the application to be complete.

Sponsoring Facility: _____

Address, City, St Zip: _____

Telephone (_____) _____ Fax (_____) _____ E-Mail:_____

We wish to sponsor _____ for a matching nursing scholarship loan.
Applicant Name

After reviewing the student's financial needs for school, we recommend the following amount of financial assistance:

(Please request an amount which reflects the student's financial needs for school and is between the minimum and maximum limitations.)

Sponsor's Share: $_____ per year or per PN program

State's Share: $_____ per year or per PN program

Total: $_____ per year or per PN program

Funding Limits	**LPN** Per PN Program	**ADN** Per Academic Year	**BSN / MSN** Per Academic Year
Minimum Total: Sponsor/State:	**$1,000** $500 / $500	**$1,000** $500 / $500	**$1,000** $500 / $500
Maximum Total: Sponsor/State:	**$3,500** $1,750 / $1,750	**$4,000** $2,000 / $2,000	**$5,000** $2,500 / $2,500

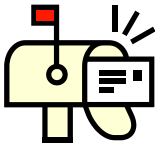
Have you read a copy of the contract that you and the applicant will be asked to sign? Yes ☐ No ☐

Is applicant related to anyone serving in a leadership capacity with your institution? Yes ☐ No ☐

If yes, please explain: _____

Representative of Sponsoring Facility: _____
Name and Title (Please Print)

_____
Signature



Mail: ❑ Application, ❑ School letter, ❑ Grades (GPA, ACT, GED), and ❑ Federal Income Tax Form:

Physician Manpower Training Commission
5500 North Western Avenue, Suite 201
Oklahoma City, Oklahoma 73118

Email: michelle.cecil@pmtc.ok.gov
Website: www.pmtc.ok.gov
Phone: (405) 843-5667

*** Faxed or emailed applications are not accepted.**
Only complete applications received by the deadline will be considered.
Not all applicants will receive funding.

The Physician Manpower Training Commission, in compliance with Title VI of the Civil Rights Act of 1974 and Title IX of the Education Amendments of 1972 (Higher Education Act), does not discriminate on the basis of race, color, national origin or sex in any of its policies, practices, or procedures. This provision includes, but is not limited to, employment and financial services.