

# APPLICANT INFORMATION

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

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

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: \_\_\_\_\_

Institution Name \_\_\_\_\_ City & State \_\_\_\_\_ Date you expect to receive your degree: \_\_\_\_\_  
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](http://www.pmtc.ok.gov/nsap.htm).

# FINANCIAL INFORMATION

Application not accepted without completion.

## Available Income

## Actual for Last Year

## Estimated for This Year

Calculate and enter annual amounts.

Calculate and enter annual amounts.

Applicant's Personal Income		
Spouse Income		
Parental Support		
Alimony		
Child Support		
School Financial Aid		
Welfare Benefits: <small>(AFDC, Food Stamps, TANF, Subsidized housing, etc.)</small>		
Social Security Benefits		
Other Income		
<b>➔ Enter Annual Totals ➔</b>	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

- 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. \_\_\_\_\_
- 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. \_\_\_\_\_
- 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 a legal resident of Oklahoma.  
 \_\_\_\_\_ I am eighteen years of age or older. \_\_\_\_\_ I would qualify for residency based on the residency status of my parents or legal guardian.

- The Physician Manpower Training Commission (PMTTC) 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:**

**Non-Relative:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
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.)	Funding Limits	LPN	ADN	BSN / MSN
		Per PN Program	Per Academic Year	Per Academic Year
<b>Sponsor's Share:</b> \$ _____ per year or per PN program	<b>Minimum Total:</b> Sponsor/State:	<b>\$1,000</b> \$500 / \$500	<b>\$1,000</b> \$500 / \$500	<b>\$1,000</b> \$500 / \$500
<b>State's Share:</b> \$ _____ per year or per PN program	<b>Maximum Total:</b> Sponsor/State:	<b>\$3,500</b> \$1,750 / \$1,750	<b>\$4,000</b> \$2,000 / \$2,000	<b>\$5,000</b> \$2,500 / \$2,500
<b>Total:</b> \$ _____ per year or per PN program				

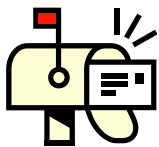
Have you read a copy of the contract that you and the applicant will be asked to sign? Yes  No

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.