

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 _____

Cell Phone (_____) _____ Second Phone (_____) _____ Personal 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 _____ Current License Number _____

Are you or have you ever worked in a health-related occupation? Yes _____ No _____ 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 _____

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

Institution Name (must be attending an OKLAHOMA nursing program) _____ City & State _____

Program of Study: LPN _____ ADN _____ BSN _____ MSN _____ MSN-NP _____ MSN-Educ _____ DNP _____ PhD _____
*Masters in Nursing Adm/Leadership does NOT qualify.

Please indicate type of program: Two-Year _____ One-Year _____ Online _____ Current overall GPA: _____ (must be 3.0 or higher)

Date you expect to receive your degree: _____ Intended dates of study in nursing program. From _____ To _____
Month Year Month/Year Month/Year

Estimate intended number of credit hours for _____ semester(s) _____

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

What are your professional goals? _____

Why do you want this scholarship? 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

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: (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 _____ A Grant or Health _____
 WIA _____ Welfare or AFDC _____ Other (name) _____

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 _____ 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 the 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. _____
- I am a legal resident of Oklahoma for the purpose of this program, a person must have maintained his/her domicile in Oklahoma for at least one year immediately prior to 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 PMTTC. I consent for verification of my work obligation upon request of the PMTTC. 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.

Deadline: July 31, 2020

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 (_____) _____ Email: _____

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

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

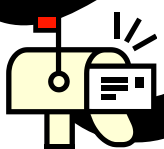
(Please request an amount which reflects the student's financial need for school and is between the minimum and maximum limitations.)	Funding	PN Per PN Program	ADN Per Academic Year	BSN Per Academic Year	MSN & Higher Per Academic Year
Sponsor's Share: \$ _____ per year of PN program					
State's Share: \$ _____ per year of PN program		\$3,000	\$5,000	\$7,000	\$10,000
Total: \$ _____ per year of PN program	_____/State:	\$1500 / \$1500	\$2500 / \$2500	\$3500 / \$3500	\$5000 / \$5000

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

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

If yes, please explain: _____

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



Main Application, School Letter of Acceptance, Official Transcript, ACT, GED Federal Income Tax Form:

Physician Manpower Training Commission
19 N. Robinson Avenue, Suite 520
Oklahoma City, Oklahoma 73102

Email: michelle.cecil@pmtc.ok.gov
Website: www.pmtc.ok.gov
Phone: (405) 604-0020

*** Faxed or emailed applications are not accepted.**
Only complete applications received by the **July 31st** deadline will be considered. **Not all applicants will receive funding.**