K-03 (Rev. 12/01)

FORM APPROVED:
OMB Approval No. 0917-0006
Exp. Date: 12/31/2007

See Estimated Average Burden Time per Response on Reverse Side

HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

ANNUAL STATUS REPORT

APPLICANT'S NAME		
STREET ADDRESS		
CITY	STATE	ZIP CODE
AREA CODE AND TELEPHONE NUMBER	SOCIAL SECURITY NUMBER	

HEALTH PROFESSION DISCIPLINE: ____________________

GRADUATION DATE: ____________________

TYPE OF DEGREE CONFERRED: ____________________

NAME OF UNIVERSITY: ____________________

ASSIGNMENT LOCATION:

- ☐ INDIAN HEALTH SERVICE
- ☐ URBAN INDIAN HEALTH PROGRAM
- ☐ PRIVATE PRACTICE
- ☐ 638 COMPACT OR CONTRACT

NAME OF FACILITY		
STREET ADDRESS		
CITY	STATE	ZIP CODE

MY CURRENT POSITION TITLE: ____________________

(ATTACH TO THIS REPORT A COPY OF YOUR PERSONNEL ORDERS OR SF-50 AND A COPY OF YOUR CURRENT POSITION DESCRIPTION.)

NON-IHS EMPLOYEES MUST ATTACH A SUMMARY WHICH IDENTIFIES THE PURPOSE, MISSION OR NATURE OF THE EMPLOYING ORGANIZATION AND THE POPULATION SERVED BY THE ORGANIZATION.

COMMENTS: ____________________

SCHOLARSHIP RECIPIENT'S SIGNATURE	DATE
IMMEDIATE SUPERVISOR'S SIGNATURE	DATE
SUPERVISOR'S TITLE	SUPERVISOR'S TELEPHONE NUMBER

Please return the completed K-03 form to IHSSP, 801 Thompson Avenue Suite 120, Rockville, MD 20852.