DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

FORM APPROVED:
OMB Approval No: 0917-0006
Exp. Date: 08/31/2013

See Estimated Average Burden Time per Response on Reverse Side.

PUBLIC LAW 94-437 – TITLE I SCHOLARSHIP PROGRAM

CHANGE OF NAME OR ADDRESS

RECIPIENT'S NAME	SOCIAL SECURITY NUMBER

ADDRESS	PHONE: CELL ☐ HOME ☐

DEGREE TRACK	IHS AREA OFFICE	EMAIL ADDRESS

INDICATE THE CHANGE YOU WOULD LIKE TO MAKE: ☐ NAME ☐ ADDRESS

NEW NAME: _____

If you have officially changed your name you must attach the appropriate legal documentation. (e.g., marriage certificate).

If you are changing your address, complete the section below. Please note that a change of address that is processed after the 10th of the month will not take affect until the following month.

NEW ADDRESS: _____

_____
City State Zip Code

NEW PHONE: ☐ Cell ☐ Home _____

DATE OF CHANGE: _____

CHECK THE APPROPRIATE BOX:

☐ I am enrolled in an undergraduate/graduate health or allied health professions program

☐ I am completing an IHS-approved post-graduate clinical training program

☐ I am fulfilling my service obligation

RECIPIENT'S SIGNATURE	DATE

Return to:
IHS Scholarship Program
Attn: Program Analyst
801 Thompson Ave., Suite 120
Rockville, MD 20852

Reviewed (IHS use only): _____
Analyst, Branch Chief or Designee

IHS-856-22 EF