CERTIFICATE OF ENROLLMENT FOR THE US ARMY HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

(For use of this form see USAREC Reg 601-37)

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 3012; 10 USC 4301; Executive Order 9397.

PRINCIPAL PURPOSE: To document and certify student enrollment and graduation data.

ROUTINE USES: The Enrollment Certificate will be used to verify status and authorize payment of scholarship entitlements. Information is used for identification purposes.

MANDATORY OR VOLUNTARY DISCLOSURE: Voluntary. If not submitted, scholarship entitlement information is considered incomplete and will not be processed.

SECTION I - TO BE COMPLETED BY HEALTH CARE RECRUITER *(Please type entries)*

1. TO *(Name and address of school)* :	2. FROM *(Recruiting office and address)* :

3. The below named individual has been accepted to participate in the U.S. Army Health Professions Scholarship Program (HPSP). Please complete Section II or Section III, as appropriate, and return this form to the above office in the enclosed self-addressed envelope. Prompt response will be appreciated as we cannot process the student's financial records without this completed form.

4. NAME OF STUDENT:	5. CURRENT ADDRESS OF STUDENT:
6. NAME AND TITLE OF REQUESTER:	7. SIGNATURE AND TELEPHONE NUMBER OF REQUESTER:

SECTION II - ENROLLED STUDENTS

(To be completed by Dean of Student Affairs or Registrar)

8. IS STUDENT CURRENTLY ENROLLED IN A FULL TIME STATUS AND IN GOOD STANDING: ☐ YES ☐ NO	9. DATE CLASSES IN NEXT ACADEMIC YEAR TO BEGIN *(Month, day, year)*:

SECTION III - INDIVIDUALS ACCEPTED FOR ENROLLMENT *(To be completed by Dean of Student Affairs or Registrar)*
(The entry in Item 11 excludes registration or orientation, unless all are the same day.)

10. DATE OR DATES OF ORIENTATION *(Month, day, year):*	11. DATE CLASSES IN NEXT ACADEMIC YEAR TO BEGIN *(Month, day, year):*
	12. DATE NEXT ACADEMIC YEAR ENDS *(Month, day, year)* :

SECTION IV - DEGREE PURSUED

13. MEDICAL ☐	20. ROTC COOP PHARMACY ☐
14. OSTEOPATHY ☐	21. ENROLLMENT STATUS:
15. DENTAL ☐ DDS ☐ DMD ☐	☐ Resident ☐ Nonresident
16. OPTOMETRY ☐	22. ESTIMATED COST OF ANNUAL TUITION AND FEES:
17. CLINICAL or COUNSELING PSYCHOLOGY ☐	Resident _____ Nonresident _____
18. NURSE ANESTHESIA, PSYCHIATRIC NURSE PRACTITIONER NURSE MIDWIFERY OR FAMILY NURSE PRACTITIONER ☐	23. PROJECTED GRADUATION DATE (Required):
19. VETERINARY MED ☐	

24. I certify that the student named above is enrolled (or accepted for enrollment) in this institution for the purpose of pursuing the graduate degree indicated and that by pursuing this course of study the student does not incur any medical practice obligations other than that which may be required by the United States Army.

25. DATE:	26. NAME AND TELEPHONE NUMBER OF DEAN:	27. SIGNATURE AND TITLE OF VERIFYING OFFICIAL: