HEALTH CARE WORKFORCE TRAINING COMMISSION
Physician Assistant Scholarship Program

APPLICATION

PLEASE PROVIDE A HEAD AND SHOULDERS PHOTO WITH THIS APPLICATION

Applicant Name _____ SS#_____
(First, Middle, Last)

Address _____
(Street/P.O. Box, City, State and Zip)

E-Mail Address _____

Phone Number ( ) _____ Cell Number ( ) _____

Birth Date _____Hometown _____

Parents Name, Address and Phone Number _____

_____

SPOUSE Marital Status _____

Spouse Name_____ Maiden Name_____SS#_____

Spouse Occupation _____ Spouse Hometown _____

Number of Children _____ Ages _____

Parents Name or Nearest Relative _____

Address and Phone No._____

College(s) Dates Attended Degree

_____

_____

Physician Assistant Training Level ◯ PA applicant ◯ 1st year ◯ 2nd year ◯ 3rd year

Location of PA Training and Anticipated Date of Completion (Mo/Yr) _____

Do you presently have any scholarships or loans that have a practice obligation? ◯ Yes ◯ No

If yes, please explain _____

Physician Assistant Scholarship Program Application (Continued)

SELECTION CRITERIA

If the number of applicants exceed the availability of funds, the following items will be used as selection criteria; (PLEASE ENCLOSE THE FOLLOWING WITH COMPLETED APPLICATION)

1) Transcript of all college work.
2) Medically related job experience. Please list location and dates of employment.
3) Acceptance Letter from an Oklahoma PA School. (Preference given to those attending Oklahoma Programs)

In what extra-curricular activities (community, hobbies, vocational) have you participated while in college and/or postgraduate training? _____

_____

List, in order of preference, the rural communities or areas in which you prefer to practice:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Please read and initial each statement below:

I understand that participation in the HWTC Physician Assistant Scholarship Program requires me to:

- Be a resident of the State of Oklahoma _____ /
- Practice in a rural community in Oklahoma upon completion of training _____ /
- Serve one month for each month the scholarship was received in a HWTC approved community _____ /

I hereby declare that the information contained in this application is true and correct.

I hereby authorize the Health Care Workforce Training Commission to request and receive all information related to the administration and enforcement of the applicable repayment agreement and promissory note.

The Health Care Workforce 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.

Signature of Applicant _____/

Date of Application _____

Please return to:

Health Care Workforce Training Commission
119 North Robinson Avenue, Suite 520
Oklahoma City, Oklahoma 73102
(405) 604-0020 FAX (405) 768-2263