**Application for Federal Funding - Traineeship**

**Please complete the data sheet and return to Laura Chafin as soon as possible.**

***DO NOT LEAVE ANY BLANKS* (Please print legibly)**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BOO# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- | --- | --- | --- | --- |
| **Current Student Address:**  **(where you want to receive correspondence about this grant)** | (Number, street, apartment #, City, State and Zip code) | | | | **Employer:** | |
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| **Phone Numbers:** | Daytime: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Evening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  |  | | | | | |
| **Gender:** | Male or Female | **Date of birth:** | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
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| **Student Email addresses:** | Personal email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  UAB email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
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| **Expected Graduation from your current program of study:** | Month and year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
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| **Specialty Track during Preceptor Training:**  **(Circle one)** | NP-Adult Gero/Occup NP-Pediatrics NP-Dual - Peds  NP-Family Practice NP-Neonatal Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NP-Nurse Educator NP-Mental Health  NP-Nursing Informatics NP-Dual Women’s Health | | | | | |
|  | | | | | | |
| **Trainee Ethnicity** | **If more than one race – specify all races**  **If other – specify all races** | | |  | |  |
| 1. American Indian/Alaskan Native 2. Asian 3. Black/African American 4. Native Hawaiian/Pacific Islander 5. White/Caucasian 6. More than one race - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. Other - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
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| **Are you a Military Veteran?**  Yes \_\_\_\_\_  No \_\_\_\_\_ | If yes, which branch: (Please circle)  Army Air National Guard  Navy Coast Guard  Air Force Other: \_\_\_\_\_\_\_\_\_\_\_\_  Marines | | | **Status:** (please circle)   1. Active Duty 2. Retired 3. Reservist 4. Veteran-more than 90 days 5. Veteran-more than 20 years 6. Served less than 90 Days | | |
|  | | | | | | |
| **After graduations, do you intend to practice in one of these locations?** (mark all that apply) | 1. Medically Underserved Community d. None of the above 2. Rural Community e. All of the above 3. Primary Care Setting | | | | | |
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| **What year are you in the master’s program? (You must mark one)** | 1. Year 1 2. Year 2 3. Year 3 4. Year 4 5. Year 5 6. Year 6 | | | | | |
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| **What type of area did you grow up?**  **(Please choose one)** | 1. Rural – pertaining to the country, country life, or country people; rustic 2. Urban – Metropolitan areas where people live 3. Suburban – a residential area 4. Frontier – a region at the edge of a settled area | | | | | |
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| **List the county and state where you attended high school:** | County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
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| **Are you from a disadvantaged background?**  Yes \_\_\_\_\_\_  No \_\_\_\_\_\_ | **Definition of disadvantaged background:** one who comes from an environment that has inhibited the individual from obtaining the knowledge, skill, and abilities required to enroll in and graduate from a health professions school, or from a program providing education or training in an allied health profession; or comes from a family with an annual income below a level based on low income thresholds according to family size published by the U.S. Bureau of Census, adjusted annually for changes in the Consumer Price Index, and adjusted by the Secretary, HHS, for use in health professions and nursing programs.  **Examples:**  (1) The individual graduated from (or last attended) a high school with low SAT score based on most recent data available: (2) The individual graduated from (or last attended) a high school from which, based on most recent data available:      (a)low percentage of seniors receive a high school diploma; or      (b)low percentage of graduates go to college during the first year after graduation. (3) The individual graduated from (or last attended) a high school with low per capita funding. (4) The individual graduated from (or last attended) a high school at which, based on most recent data available, many of the enrolled students are eligible for free or reduced price lunches. (5) The individual comes from a family that receives public assistance (e.g., Aid to Families with Dependent Children, food stamps, Medicaid, public housing). (6) The individual comes from a family that lives in an area that is designated under section 332 of the Act as a health professional shortage area. | | | | | |
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| **Trainee enrollment status:** | 1. Full time (at least 9 credit hours) 2. Part time (less than 9 credit hours but more than 6 credit hours) | | | | | |
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| **Is your FAFSA Completed?** | Yes\_\_\_\_\_ No\_\_\_\_\_\_  If no, please complete the FAFSA prior to making this application.  Use School Code: 001052 | | | | | |
|  |  | | | | | |
| **Are you eligible for any tuition reimbursement or assistance with your employer? Or another source?** | Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_  How much you will receive from employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Will you receive these funds each semester or yearly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List other sources of financial support you will receive and the amount: (scholarship, grant, etc)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
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**Acknowledgement:**

I, the above named applicant, have been informed that I must agree to the service obligation associated with the NFLP, AENT, NAT or SDS in order to be eligible to receive HRSA funding under this program. This includes completing annual reports for information relating to your receiving funding for up to one year following graduation from the program. I, also, agree with this signature and acceptance of any award funding, that I am not or have never been in default of any federal loan program. The above information is correct and complete and I hereby authorize verification as required by the School.

**Printed Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print & Fax to**: 205-996-5709 **or Mail to:** Laura Chafin, UAB School of Nursing

**Or email to:** [chafinl@uab.edu](mailto:chafinl@uab.edu) NB202D, 1720 2nd Avenue, South

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