

Application for Federal Funding - Nurse Faculty Loan

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

DO NOT LEAVE ANY BLANKS (Please print legibly)

Name: _____ BOO# _____

Current Student Address: <small>(where you want to receive correspondence about this grant)</small>	Street _____ County _____ City _____ State _____ Zip Code _____	Program: DNP <input type="checkbox"/> PhD <input type="checkbox"/>
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Phone Numbers:	Daytime: _____	Evening: _____	Cell: _____
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Gender: _____	Date of birth: _____
Personal email address: _____	
UAB email address: _____	
Expected Graduation from your current program of study: Month and year: _____	

Employer: (Name address, Phone and County)	Name: _____ Phone: _____	
	Address: _____	
	City _____	County _____ State _____ Zip Code _____

If more than one race - specify all races		
If other - specify all races		
Ethnicity	Race _____	If Multiracial _____
		If Other _____

Are you a Military Veteran?	If yes, which branch: (Please circle) _____ If Other _____	Status: _____ _____
Yes <input type="checkbox"/> No <input type="checkbox"/>		

After graduations, do you intend to work in Nurse Faculty Role	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, as part of receiving funding for the Nurse Faculty Loan Program, you agree to provide the Name of your employer to us for reporting purposes only to grant funding source. All information is confidential. Funding source does not receive any personal information.
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What year are you in the doctoral program? (You must Choose one) _____

What type of area are you currently Living? _____
(Please choose one)

List the county and state where you attended high school: County _____
State _____

<p>Are you from a disadvantaged background?</p> <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>	<p>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.</p> <p>Examples:</p> <p>(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.</p>
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Enrollment status: _____

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)

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 Name If submitting By email

Or email to: chafinl@uab.edu
Phone #: 205-934-3485

Print & Fax to: 205-996-5709

or Mail to: Laura Chafin, UAB School of Nursing
NB202D, 1720 2nd Avenue, South
Birmingham, AL 35294-1210