Academic Faculty/Advisor Evaluation Form

Applicant:

Provide your designated Academic Evaluator with a copy of this instruction sheet and evaluation form via email or hard copy. It is the applicant's responsibility to ensure that your designated Evaluator received, completed, and mailed their completed and signed evaluations to NHHSP on your behalf.

NOTE: The Academic Faculty/Advisor Evaluation Form is MANDATORY

Evaluator:

Please complete, sign, and return the attached evaluator form to the address indicated below.

If additional space is required, use additional sheets of 8.5x11" paper. Write your name and the applicant's name on each additional sheet of paper. Securely attach additional sheets to this form.

If you have any questions, contact the NHHSP Administrative Assistant at (808) 597-6550 ext.203 or email adminassist@nhhsp.org

Mail or email required documents to:

Native Hawaiian Health Scholarship Program
ATTN: NHHSP Administrative Assistant
894 Queen Street
Honolulu HI 96813

Email: adminassist@nhhsp.org

Due no later than April 30, 2018

U.S. Department of Health and Human Services
Health Resources & Services Administration
Papa Ola Lōkahi

Title 42 USC Chapter 122 Section 11709 – Native Hawaiian Health Scholarship Program

Academic Evaluation Form

APPLICANTS' NAME _____ eMAIL Address _____ Phone: □ Cell □Home _____

COLLEGE/UNIVERSITY NAME _____ PROJECTED GRADUATION MO/YR _____

The student/NHHSP Applicant, identified above, is applying for a Scholarship with the Native Hawaiian Health Scholarship Program (NHHSP). The requested information is pursuant to Section 751-756 of the Public Health Service Act, and the applicable program regulations which provide for consideration be given, based on academic faculty/advisor recommendation when evaluating and selecting individuals for scholarships.

The information provide on this form is treated as confidential and may only be disclosed outside the U.S. Department of Health and Human Services in accordance with provisions of the Privacy Act of 1974 (P.L. 93-579) and the terms and conditions of the applicable Privacy Act Notice published by the Department in the *Federal Register.*

Please return the completed & signed "Academic Evaluation" Form directly to NHHSP.

1. How do you rate the educational and/or work achievement of this Applicant?

5 - □ Outstanding 4 - □ Above Average 3 - □ Average 2 - □ Below Average 1 - □ Poor

Comments: _____

2. How do you rate the Applicant's relationships with other people? Consider such things as ability to work and get along with others.

5 - □ Outstanding 4 - □ Above Average 3 - □ Average 2 - □ Below Average 1 - □ Poor

Comments: _____

3. Based on this Applicant's personal, emotional, and ethical attributes, how do you rate his/her overall potential for the practice of primary health care, especially in a Health Provider Shortage Area (HPSA)?

5 - □ Outstanding 4 - □ Above Average 3 - □ Average 2 - □ Below Average 1 - □ Poor

Comments: _____

4. Relationship to NHHSP Applicant: _____
5. How long have you known the Applicant?

Statement of Conflict of Interest: I certify, I am not related to the NHHSP Applicant by blood or marriage. I certify that the information provided in this evaluation is accurate. I understand that it may be investigated and that any willfully false representation is sufficient for rejection of this application.

Evaluator Name (Print or Type) **eMAIL** **Phone: □ Cell □Home**

Position Title (Required) **Place of Employment (required)**

Signature **Date**

✓

Employer Evaluation Form

Applicant:

Provide your designated Employer Evaluator with a copy of this instruction sheet and evaluation form via email or hard copy. It is the applicant's responsibility to ensure that your designated Evaluator received, completed, and mailed their completed and signed evaluations to NHHSP on your behalf.

NOTE: If you are currently unemployed, a Community Resource/Personal Reference Evaluation form may be completed and submitted in lieu of an Employer Evaluation Form

Evaluator:

Please complete, sign, and return the attached evaluator form to the address indicated below.

If additional space is required, use additional sheets of 8.5x11" paper. Write your name and the applicant's name on each additional sheet of paper. Securely attach additional sheets to this form.

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Health Resources & Services Administration
Papa Ola Lōkahi

Title 42 USC Chapter 122 Section 11709 – Native Hawaiian Health Scholarship Program

Employer Evaluation Form

APPLICANTS' NAME | **eMAIL Address** | **Phone: □ Cell □Home**

COLLEGE/UNIVERSITY NAME | **PROJECTED GRADUATION MO/YR**

The student/NHHSP Applicant, identified above, is applying for a Scholarship with the Native Hawaiian Health Scholarship Program (NHHSP). The requested information is pursuant to Section 751-756 of the Public Health Service Act, and the applicable program regulations which provide for consideration be given, based on academic faculty/advisor recommendation when evaluating and selecting individuals for scholarships.

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Please return this completed & signed "Employer Evaluation" Form directly to NHHSP.

1. How do you rate the educational and/or work achievement of this Applicant?

5 - □ Outstanding 4 - □ Above Average 3 - □ Average 2 - □ Below Average 1 - □ Poor

Comments:

2. How do you rate the Applicant's relationships with other people? Consider such things as ability to work and get along with others.

5 - □ Outstanding 4 - □ Above Average 3 - □ Average 2 - □ Below Average 1 - □ Poor

Comments:

3. Based on this Applicant's personal, emotional, and ethical attributes, how do you rate his/her overall potential for the practice of primary health care, especially in a Health Provider Shortage Area (HPSA)?

5 - □ Outstanding 4 - □ Above Average 3 - □ Average 2 - □ Below Average 1 - □ Poor

Comments:

4. Relationship to NHHSP Applicant:
5. How long have you known the Applicant?

Statement of Conflict of Interest: I certify, I am not related to the NHHSP Applicant by blood or marriage. I certify that the information provided in this evaluation is accurate. I understand that it may be investigated and that any willfully false representation is sufficient for rejection of this application.

Evaluator Name (Print or Type) | **eMAIL** | **Phone: □ Cell □Home**

Position Title (Required) | **Employer Name**

Signature ✓ | **Date**

U.S. Department of Health and Human Services
Health Resources & Services Administration
Papa Ola Lōkahi

Title 42 USC Chapter 122 Section 11709 – Native Hawaiian Health Scholarship Program

Community Evaluation Form

APPLICANTS' NAME | eMAIL Address | Phone: ☐ Cell ☐Home

COLLEGE/UNIVERSITY NAME | PROJECTED GRADUATION MO/YR

The student/NHHSP Applicant, identified above, is applying for a Scholarship with the Native Hawaiian Health Scholarship Program (NHHSP). The requested information is pursuant to Section 751-756 of the Public Health Service Act, and the applicable program regulations which provide for consideration be given, based on academic faculty/advisor recommendation when evaluating and selecting individuals for scholarships.

The information provide on this form is treated as confidential and may only be disclosed outside the U.S. Department of Health and Human Services in accordance with provisions of the Privacy Act of 1974 (P.L. 93-579) and the terms and conditions of the applicable Privacy Act Notice published by the Department in the *Federal Register.*

Please return this completed & signed "Community Resource/Personal Evaluation" Form directly to NHHSP

1. How do you rate the educational and/or work achievement of this Applicant?

5 - ☐ Outstanding 4 - ☐ Above Average 3 - ☐ Average 2 - ☐ Below Average 1 - ☐ Poor

Comments:

2. How do you rate the Applicant's relationships with other people? Consider such things as ability to work and get along with others.

5 - ☐ Outstanding 4 - ☐ Above Average 3 - ☐ Average 2 - ☐ Below Average 1 - ☐ Poor

Comments:

3. Based on this Applicant's personal, emotional, and ethical attributes, how do you rate his/her overall potential for the practice of primary health care, especially in a Health Provider Shortage Area (HPSA)?

5 - ☐ Outstanding 4 - ☐ Above Average 3 - ☐ Average 2 - ☐ Below Average 1 - ☐ Poor

Comments:

4. Relationship to NHHSP Applicant:
5. How long have you known the Applicant?

Statement of Conflict of Interest: I certify, I am not related to the NHHSP Applicant by blood or marriage. I certify that the information provided in this evaluation is accurate. I understand that it may be investigated and that any willfully false representation is sufficient for rejection of this application.

Evaluator Name (Print or Type) | **eMAIL** | **Phone: ☐ Cell ☐Home**

Position Title (Required) | **Organization/Agency Name**

Signature ✓ | **Date**

Community Resource/Personal Reference Evaluation Form

Applicant:

Provide your designated Community Resource/Personal Reference Evaluator with a copy of this instruction sheet and evaluation form via email or hard copy. It is the applicant's responsibility to ensure that your designated Evaluator received, completed, and mailed their completed and signed evaluations to NHHSP on your behalf.

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Evaluator:

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