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SCHOLARSHIP PROGRAM VERIFICATION (SPV) FORM

INSTRUCTIONS:

- This form is to be completed by students enrolled or scheduled to be enrolled in a program that are pursuing a course of study leading to a professional degree.
- This form must be signed by the Registrar's Office, Program Director, or Appropriate Designee **ONLY**.
- Applicant must upload the signed and completed form as part of their Department of Health Care Access and Information (HCAI) Scholarship Program application.
- With the exception of the GPA, any missing or incomplete information will deem the application ineligible.

PLEASE ENTER ALL INFORMATION CLEARLY

First Name:		Last Name:	
Name of School/Institution:			
School/Institution Address:	Street:		
	City:	State:	
	Zip/Postal Code:	County:	
Major/Concentration:			
Degree Sought:		Program Start Date:	
By checking this box, Applicant certifies that they are enrolled or scheduled to be enrolled in a minimum of six (6) semester units/credits. <u>*A minimum of 6 semester units or its equivalent is required*</u>			
Type of Units:	Semester	Quarter	Other: _____
<u>*Enter your most recent GPA. If program has not started, you may enter your High School GPA if that is the highest education received to date.*</u>			
Student's Cumulative GPA: _____		GPA Unavailable	
Student's <u>Expected</u> Graduation/Completion Date: _____			

TO BE SIGNED BY THE REGISTRAR'S OFFICE, PROGRAM DIRECTOR, OR APPROPRIATE DESIGNEE ONLY

I DECLARE THAT THESE STATEMENTS ARE TRUE AND CORRECT.

_____ Signature	_____ Date
_____ Printed First and Last Name	_____ Email