HEALTH CARE WORKFORCE TRAINING COMMISSION
Family Practice Resident Rural Scholarship

APPLICATION

Name _____ ◯ M.D. ◯ D.O. SS# _____
(First, Middle, Last) (Select one)

Medical License Number(s) List All _____ Maiden Name _____

Do you have now, or have your ever had a restricted license? ◯ Yes ◯ No (If yes, please explain)

_____

Address _____
(Street/P.O. Box, City, State and Zip) (E-mail address)

Phone Number ( ) _____ Cell Number ( ) _____

Birth Date ___/___/___ Hometown _____ Marital Status _____

Spouse Name _____ Maiden Name _____ SS# _____

Spouse Occupation _____ Spouse Hometown _____

Number of Children _____ Ages _____

Applicant: Parents' Name, Address and Phone _____

_____

Medical College(s), City and State Dates Attended

_____

_____

Family Practice/General Practice Training Institution, City and State Dates Attended

_____

_____

Family Practice/General Practice Residency Level ◯ 1st year ◯ 2nd year ◯ 3rd year

Anticipated Date of Completion (Mo/Yr) _____

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

_____

Family Practice Resident Rural Scholarship Program Application
Continued

Do you know a rural community that will sponsor you? ◯ Yes ◯ No

If yes, name of town_____

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

1) _____

2) _____

3) _____

Explain your community/state area choice:

_____

_____

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

If yes, please explain _____

Please read and initial each statement below:

I understand that participation in the HWTC Resident Rural Scholarship Program requires me to:

- Select and match with a community on or before the end of the second year of residency training ____ ✓
- Complete a one-month elective rotation in the matched community in third year of residency training ____ ✓

The Health Care Workforce Training Commission is given permission to contact any parties or to obtain the sources of information, which it deems necessary to verify my eligibility for this scholarship/loan.

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.

I hereby declare that the information contained in this application is true and correct to the best of my knowledge.

Signature of Applicant _____✓

Date of Application _____

***PLEASE INCLUDE A PICTURE WITH THIS 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

10/06/2022