APPLICANT INFORMATION

Application will not be considered if all blanks are not completed.

Have you received assistance through the Oklahoma Nursing Student Assistance Program in the past? Yes ☐ No ☐
If yes, what years was it received?

OFFICE USE ONLY: Fulfilled ❑

Check the type for which you are applying: ☐ Non-Matching ☐ Matching (Sponsor must complete the Sponsor section on the back page of Matching applications. Only one application and sponsor per applicant.)

Name: _____
Last First Middle (Maiden if applicable)

Date of Birth (Required):_____ Social Security Number:_____

Permanent Address (where mail will always reach you):_____

City, State:_____ Zip+4 (Use 9-digit Zip Code):_____ County:_____

Cell Phone: (_____) _____ Second Phone: (_____) _____ Personal Email: _____
Do not list school or work email

List dates lived in Oklahoma _____

Are you a U.S. Citizen*? Yes _____ No _____
Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ (***Must be a U.S. Citizen in order to apply**.)

Name of Spouse: _____ Spouse Social Security Number: _____
Must be entered even if separated

Spouse Occupation: _____ Spouse Employer _____

Number of Dependents other than yourself and spouse: _____ Ages: _____ _____ _____ _____ _____ _____ _____

Do dependents live in your household? Yes _____ No _____ If no, explain _____

Are you currently licensed to practice as a LPN or RN in Oklahoma? Yes ☐ No ☐ Current License Number _____

Are you or have you ever worked in a health-related occupation? Yes ☐ No ☐ If so, how long? _____

Where and in what capacity? _____

Present Employer and Address: _____

STUDY PLANS

Check semester(s)you will be enrolled in nursing program: ☐ Fall 20_____ ☐ Spring 20_____

University, college, or technical school where you have been admitted into the nursing program:***program must be based in OKLAHOMA to qualify, even if online***

_____ _____
Institution Name (**must be attending an OKLAHOMA nursing program**) City & State

Program of Study: LPN ☐ ADN ☐ BSN ☐ MSN ☐ MSN-NP ☐ MSN-Educ ☐ DNP ☐ PhD ☐
***Masters of Nursing Adm/Leadership does NOT qualify.**

Please indicate type of program: On Campus ☐ Online ☐ Current overall GPA:_____ **(*must be 3.0 or higher to qualify*)**

Month/Year you expect to receive your degree: _____ List intended dates of study in nursing program From:_____ To:_____

Estimate intended number of credit hours for Fall, _____Spring, _____

Do you plan to work while attending school? Yes ☐ No ☐ If yes, how many hours per week? _____

What are your professional goals? _____

_____

Many people apply for this scholarship loan. Please give reasons you feel you should be selected: _____

_____

_____

In what community do you plan to practice nursing? *****OKC and Tulsa metro areas **do not** qualify***** _____

If applying for a matching scholarship, are you related to the owner or an employee of the sponsoring institution? Yes ☐ No ☐

If yes, please give name and relationship: _____

Have you read a copy of the contract you will be asked to sign if you are awarded a scholarship loan? Yes ☐ No ☐ (Sample available on our website.)

For more information regarding the scholarship, and a list of non-qualifying communities for obligated practice go to: oklahoma.gov/hwtc

FINANCIAL INFORMATION

Available Income	Actual for Last Year Calculate and enter annual amounts	Estimated for This Year Calculate and enter annual amounts
Applicant's Personal Income		
Spouse Income		
Parental Support		
Alimony		
Child Support		
School Financial Aid		
Welfare Benefits: (AFDC, Food Stamps, TANF, Subsidized housing, etc.)		
Social Security Benefits		
Other Income		
→ **Enter Annual Totals** →	Total Received	Estimated Total

Are you currently, or will you be receiving assistance from any of the following? **ENTER FINANCIAL AMOUNTS ABOVE.**

Stafford _____ Pell Grant _____ Vocational Rehabilitation _____

OTAG _____ Perkins _____ Low Income Housing _____

SEOG _____ Food Stamps _____ BIA Grant or Indian Health _____

WIA _____ Welfare or AFDC _____ Other (name source) _____

Will any family member living in your household, other than yourself, be enrolled in college? Yes ☐ No ☐ How many? _____

Have you received or applied for other assistance with a work obligation? Yes ☐ No ☐ Please explain: _____

Estimated cost of attendance: Tuition and Fees $ _____ Uniforms and Supplies $ _____

Books $_____ Transportation $_____ Total commuting miles per week: _____

Where will you live during the school year? With Parents ☐ On Campus ☐ Off Campus ☐

Are you currently in default or delinquent in payment on a student loan? Yes ☐ No ☐ If yes, please explain: _____

Have you ever been convicted of a felony? Yes ☐ No ☐ If yes, verification of eligibility documentation from the Oklahoma Board of Nursing must be submitted with application.

APPLICANT'S STATEMENT

Read & Initial

1. I am applying for financial assistance as an incentive to complete my education in nursing and to provide professional services in a health/sickness care institution, state agency or educational institution in Oklahoma. 1. _____

2. **Matching Scholarship Program.** I understand that the receipt of loan funds requires a full-time practice obligation of one year with the sponsor as specified in this application for each year of financial support received (with a minimum of one year) or repayment of scholarship funds plus interest and/or liquidated damages. 2. _____

   Non-Matching Scholarship Program. I understand that the receipt of loan funds requires a full-time practice obligation of one year in the State of Oklahoma for each year of financial support received (with a minimum of one year) or repayment of scholarship funds plus interest and/or liquidated damages. _____

3. To qualify as a legal resident for the purpose of this program, a person must have maintained his/her domicile in Oklahoma for at least one year immediately prior to a request for funds and qualify for resident tuition. If the applicant is under eighteen, or dependent, the status of the domicile is determined by that of his/her parents or legal guardian. 3. _____

CHECK ALL THAT APPLY.

☐ I am twenty-three years of age or older.
☐ I am eighteen years of age or older.
☐ I am a legal resident of Oklahoma.
☐ I would qualify for residency based on the residency status of my parents or legal guardian.

4. The Health Care Workforce Training Commission (HWTC) is given permission to contact any parties or to obtain the sources of information which it deems necessary to verify my eligibility for a loan. I consent for my nursing school to release my grades or my status in school upon request of the HWTC. I consent for verification of my work obligation upon request of the HWTC. 4. _____

   The information given in this application and supporting forms is accurate and true to the best of my knowledge. I understand that if I knowingly make a false statement or misrepresentation on this application or any of the required supporting documents, it will be grounds for termination of the loan, immediate repayment of any funds already paid to me, and possible criminal action.

_____ _____

Date **Applicant Signature**

Application must be completed on back page.

REFERENCES

Relative

Name

Relationship

Address

City, State, Zip

Phone Number

Non-Relative

Name of non-relative

Relationship

Address

City, State, Zip

Phone Number

SPONSOR SECTION

Nursing Student Assistance Program

In order for the application to be processed as matching, the sponsoring institution must complete this section

- Sponsor funds must be sent to HWTC in order for the funds to be matched
- HWTC cannot match any funds that have been paid directly to the student
- **We will invoice the facility for those funds at the end of each semester/at the end of LPN program for LPN recipients.**
- *The recipient will receive semester payments at the end of each semester after we have verified status and progression in the program and after we have received the sponsor funds for that semester*

Please be sure to include the name of the person that will be the contact person for this scholarship program if it is someone other than the signing representative

Sponsoring facility:_____

Contact Representative: _____

Contact Email: _____

Address, City, Zip Code: _____

Telephone (_____) _____ Fax (_____) _____

We wish to sponsor _____ for a matching nursing scholarship loan.

Sponsor's Share: $_____ per year or per PN program

State's Share: $_____per year or per PN program

Total: $_____per year or per PN program

LPN	ADN	BSN	MSN & higher
Per PN Program	**Per Academic Year**		
$3,000.00	$5,000.00	$7,000.00	$10,000.00
Sponsor/State $1500/$1500	**Sponsor/State** $2500/$2500	**Sponsor/State** $3500/$3500	**Sponsor/State** $5000/$5000

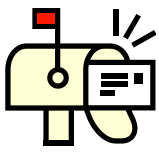
Have you read a copy of the contract that you and the applicant will be asked to sign? Yes ____ No ____

Representative of Sponsoring Facility: _____

Name and Title (Please Print)

_____

Signature



Mail: ❑ Application, ❑ School Letter of Acceptance, ❑ Official Transcript, ACT, GED

Health Care Workforce Training Commission
119 N. Robinson Avenue, Suite 225
Oklahoma City, Oklahoma 73102

Email: michelle.cecil@hwtc.ok.gov
aleigha.oldcrow@hwtc.ok.gov

Website: www.oklahoma.gov/hwtc.html

Phone: (405) 604-0020

Faxed or emailed applications are not accepted

Only complete applications received by the JULY 15, 2026 deadline will be considered.

Not all applicants will receive funding.

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.