ACADEMIC YEAR STATEMENT

In order to establish an exact benefit start date, the student and the school registrar must complete the information below carefully. This form will be returned to the HPSP participant if received without proper school endorsement, recipient's signature or incomplete fields, which may affect tuition and/or benefit payments. Please scan and email completed form, as well as any questions, to: USN.OHSTUDENT@MAIL.MIL. PLEASE PRINT CLEARLY!!

Full Name of Student	Last Four of Social Security Number	E-mail Address

School Information: Program (circle one): Medical / Dental / Optometry / PA / Podiatry / NADDS / FAP

School Name: _____

School Address: _____
(Street) (City) (State) (Zip)

School Registrar Information

NOTE: Please be precise when entering the below dates. An error could result in loss of pay and/or benefits for this student. Please do not include periods of orientation.

Exact beginning date of student's current academic year: _____ (MM/DD/YY)
Exact graduation date for this student: _____ (MM/DD/YY)
1. Is this student considered a state resident for tuition purposes? (circle one) YES / NO
2. Tuition/mandatory fees in the amount of $ _____ is paid (circle one): per year / per semester / per trimester / per quarter
3. If a dental student, what is the cost of the mandatory dental kit? $ _____
4. Registrar Printed Name:
Registrar Signature: Date:
Phone: Fax:
Email:

As a recipient of the Armed Forces Health Professions Scholarship Program (HPSP), Nurse Candidate Program (NCP), Financial Assistance Program (FAP), or Navy Active Duty Delay for Specialists (NADDS), I hereby authorized my university permission to release any and all information relating to my academic performance and/or enrollment status to Navy Accessions, Bureau of Medicine and Surgery, if requested.

STUDENT SIGNATURE: _____ Date: _____

FOR OFFICIAL USE ONLY – PRIVACY SENSITIVE – Any misuse or unauthorized disclosure can result in both civil and criminal penalties.