

**Loan  
Application**

**NORTHWEST OKLAHOMA HEALTHCARE  
EDUCATION COALITION**

**Personal**

Name \_\_\_\_\_  
Last First Middle

Social Security Number \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Marital Status: Single Married Divorced Separated Widowed (circle one)

Present Address \_\_\_\_\_  
Street City State Zip

Permanent Address \_\_\_\_\_  
Street City State Zip

Name of Spouse \_\_\_\_\_ Occupation \_\_\_\_\_

Spouses Employer \_\_\_\_\_  
Place Address City State Zip

Dependents other than yourself and spouse \_\_\_\_\_  
Please list age of each dependent

**Study Plans**

Name and Address of Institution \_\_\_\_\_  
Institution

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Program of Study \_\_\_\_\_ Date Classes Begin \_\_\_\_\_

Have you been accepted to this program \_\_\_ Yes \_\_\_ No If yes, please attach documentation.

Are you currently certified or licensed in any area of Healthcare? \_\_\_ Yes \_\_\_ No

If yes, please list and attach documentation of any Healthcare accreditation.

Do you expect to work while attending such program \_\_\_ Yes \_\_\_ No. If yes, \_\_\_ FT \_\_\_ PT

Have you read the contract you will be asked to sign if you are selected \_\_\_ Yes \_\_\_ No

Indicate amount of loan \$ \_\_\_\_\_ required.

Are you currently in default or delinquent in payment on a student loan? \_\_\_ Yes \_\_\_ No

Please list other assistance programs you are applying. Candidates applying to other scholarship/loan programs which require a service obligation will not be considered, this does not include scholarship/grant type programs.

What are your professional goals?

Northwest Oklahoma Healthcare Coalition 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, age, and sex in any of its policies, practices or procedures. This provision includes but is not limited to employment and financial services.

**Previous Education**

Years Completed	Institution & Address	Major/minor	Year Graduated
High School			
Vocational School			
College/University			
Nursing School			
Other Training			

Please attach transcripts of all education

**Work Experience**

Please start with your most recent employer and work back through previous positions.

1. Present (or most recent) employer \_\_\_\_\_ Phone \_\_\_\_\_  
Address, City, State, Zip \_\_\_\_\_  
Date Started \_\_\_\_\_ Date Ended \_\_\_\_\_ Supervisor \_\_\_\_\_  
Title and duties \_\_\_\_\_  
Reason for leaving if not currently employed \_\_\_\_\_
2. Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Address, City, State, Zip \_\_\_\_\_  
Date Started \_\_\_\_\_ Date Ended \_\_\_\_\_ Supervisor \_\_\_\_\_  
Title and Duties \_\_\_\_\_  
Reason for leaving \_\_\_\_\_
3. Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Address, City, State, Zip \_\_\_\_\_  
Date Started \_\_\_\_\_ Date Ended \_\_\_\_\_ Supervisor \_\_\_\_\_  
Title and duties \_\_\_\_\_  
Reason for leaving \_\_\_\_\_

**References**

_____	_____
Name	Name
_____	_____
Relationship	Relationship
_____	_____
Address	Address
_____	_____
City, State, Zip	City, State, Zip
_____	_____
Phone	Phone

**Important – please read**

I am applying for financial assistance as an incentive to complete my education. I understand that the receipt of funds require an employment obligation as set forth in my agreement or repayment of funds plus interest and/or penalty. Also, I realize that I must maintain continuous enrollment, maintain acceptable grades and am a student in good standing at all times. Additionally, I certify that I am at least eighteen years of age and a legal resident of Oklahoma or qualify for residency based on the residency status of my parents/legal guardian.

I certify that all statements made in this application are true and complete to the best of my knowledge. I also understand that any false statements or omissions in this application will result in my application being rejected or my funding terminated. I do hereby authorize any and all investigations deemed necessary by the committee to verify the information contained herein and release the Northwest Oklahoma Healthcare Education Coalition from any/all liability resulting from such investigation. I understand that the Northwest Oklahoma Healthcare Education Coalition will not inform me of the details of any information gleaned from investigations.

Signature \_\_\_\_\_ Date \_\_\_\_\_

APPLICATIONS SHOULD BE RETURNED TO: RURAL HEALTH PROJECTS, INC.  
2929 E RANDOLPH Rm 130  
ENID, OK 73701