



# State of Wisconsin Higher Educational Aids Board

Tony Evers  
Governor

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## Health Services Scholarship Program

### Notice of Intent to Practice in a Health Shortage Area in the State of Wisconsin

#### Applicant Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

#### Health Care Training Program

I am currently enrolled in a Health Care Training Program and my area of specialty or sub-specialty is:

- Primary Care Physician     Physician's Assistant     Nurse Practitioner
- Dentist     Psychiatrist

Residency Program Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Dental/Medical School Attending: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Nursing School Attending: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

#### Statement of Intent

*I intend to seek employment working in an area which qualifies as a **designated Health Shortage Area in Wisconsin at the time I start my employment.** I understand that once I am employed in this capacity I must annually submit, to the Higher Educational Aids Board, proof of practice in a Health Shortage Area in Wisconsin and proof of continued licensure in my stated profession. Original or electronic signatures will be accepted.*

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

#### School Verification of Applicant's Enrollment

As a representative of the financial aid office of the Applicant's Dental/Medical School listed in this application, I certify that the information provided on this form is correct and that the applicant is currently enrolled as a student at this school.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

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

**Financial aid office: return all completed forms at one time to:**

Mail: HEAB-HSSP  
PO Box 7885  
Madison, WI 53707

Email: [joy.dyer@wisconsin.gov](mailto:joy.dyer@wisconsin.gov)  
Fax: 608-267-2808

**For more information, contact:**

Joy Dyer, HEAB Grant Specialist  
Phone: 608-267-2212 or email