State of Wisconsin
Higher Educational Aids Board

P.O. Box 7885
Madison, WI 53707-7885
HEABmail@wisconsin.gov

Telephone: (608) 267-2206
Fax: (608) 267-2808
https://heab.state.wi.us

Tony Evers
Governor

Connie Hutchison, PhD
Executive Secretary

Health Services Scholarship Program
Verification of Practice Form

An individual may submit a Verification of Practice Form if: 1) the individual has a valid Notice of Intent to Practice in a Health Shortage Area in the State of Wisconsin Form on file with the Higher Educational Aids Board (HEAB); 2) the individual has completed a Health Care Training Program in the State of Wisconsin in a qualifying specialty or sub-specialty; and 3) the individual has practiced for at least **12** months after completing the program in an area that qualified as a **designated Health Shortage Area in the State of Wisconsin at the start of the individual's employment**.

A scholarship recipient must annually submit the Verification of Practice Form to HEAB. To fulfill the scholarship requirements, a scholarship recipient must be employed in an approved Health Shortage Area in the State of Wisconsin for a period equal to ***18 months for each annual scholarship accepted by the recipient***. If the scholarship recipient fails to practice in a designated Health Shortage Area in this state for the required period, she or he must repay to the state an amount equal to the **total dollar amount of annual scholarships awarded to the student multiplied by the student's repayment liability percentage.** The scholarship then becomes a loan.

Scholarship Recipients: Please complete sections A, B, C and D; section E must be completed by your employer. Please mail completed forms, along with any required documentation (see Mailing Instructions below), annually to HEAB.

Section A: SCHOLARSHIP RECIPIENT INFORMATION

_____ _____
First Name Middle Initial Last Name Social Security Number*

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

*Social security number is required for reporting award disbursement to the IRS.

Section B: EMPLOYMENT INFORMATION

I am currently practicing in my area of specialty or sub-specialty as a:

☐ Primary Care Physician ☐ Physician's Assistant ☐ Nurse Practitioner

☐ Dentist ☐ Psychiatrist

Name of Employer or Affiliated Organization: _____

Work Address (physical location): _____

City: _____ State: _____ Zip: _____

Date employment offer accepted: _____ Date employment began: _____

Section C: PRACTICING IN A HEALTH SHORTAGE AREA

Through employment listed in section B, I am currently practicing in the following type of Health Shortage Area in Wisconsin:
Note: If HPSA, the HPSA designation must be in your discipline (primary care, dental, or mental health).

☐ HPSA-Geographic Area ☐ HPSA-Population Group ☐ HPSA-Facility

☐ MUA/MUP ☐ Governor's Designated Shortage Area for Rural Health Clinics

Average number of hours per week that you are practicing in the underserved area(s): _____

Section D: SCHOLARSHIP RECIPIENT CERTIFICATION

I certify that the information listed in sections A, B, and C is true.

Signature: _____ Date: _____

Section E: EMPLOYER CERTIFICATION

As a representative of the organization listed in Section B of this form, I certify that the information provided on this form is correct and the scholarship recipient is currently an employee or affiliated with this organization.

Name: _____ Title: _____

Signature: _____ Date: _____

Mailing Instructions: Annually mail the completed Verification of Practice Form to HEAB. If this is the first time you are submitting a Verification of Practice Form, you must also provide proof of a permanent dental, medical, or mental health license, physician's assistant or nurse practitioner's license in the State of Wisconsin, as well as proof of completion of a Health Care Training Program in the State of Wisconsin in a specialty or sub-specialty as indicated in section B.

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

For questions, please contact:
Joy Dyer, HEAB Grant Specialist
Phone: 608-267-2212
Email: joy.dyer@wi.gov