NARHC REF
Research & Education Foundation

SCHOLARSHIP APPLICATION FORM

Instructions: Complete the following fields and provide clear and concise responses to each question, ensuring all information is accurate and addresses each prompt directly. If you need additional space, feel free to attach extra sheets, making sure to label each one with your name included. **Please email your completed form to sarah.hohman@narhc.org.**

***The following documentation must also be included with this application:**

- Unofficial transcripts from the current school

Section 1: Applicant Information			
First Name:		**Applicant ID:** *(REF use only)*	
Last Name:		**Phone:**	
Email Address *(personal):*			
Email Address *(School):*			
Mailing Address:			
Home City:		**Home State:**	
Gender:	Select an option		
Race:	Select an option	**Ethnicity:**	Select an option
Current Credential (if applicable): *(Ex: Registered Nurse, Certified Medical Assistant)*			
Name of Undergraduate School:			
Undergraduate Degree:		**Major:**	
Section 2: Academic Program Details			
Name of School:			
Enrolled Program:			
Major Course of Study and/or desired degree, certificate, or licensure: *(Ex: Associate Degree in Nursing, Doctor of Pharmacy)*			
Enrollment Status:	☐ *Full-Time* ☐ *Part-Time*		
Anticipate Graduation Date:			

Please email any questions or concerns to sarah.hohman@narhc.org

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Intended Profession:	
Intended Specialty (if applicable):	
Name of Undergraduate School Attended (if applicable):	

Section 3: Clinical Rotation Details			
Please confirm at qcor.cms.gov that the facility you plan to complete your rotation in is a CMS certified Rural Health Clinic.			
Rural Health Clinic Name:			
Clinic Address:			
Intended Start Date:		**End Date:**	
Designated Preceptor/ Administrative Contact Name:			

Explain why you are choosing to complete a rotation in a Rural Health Clinic.
What does *'Access to Quality Health Care'* mean to you?

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Why are you applying for the *Quest for Rural Experience Scholarship*, and how do you hope to advance rural health in the future?

☐ ***I hereby*** *agree to complete a written evaluation of my experience at the conclusion of rotation with the National Association of Rural Health Clinics Research and Education Foundation (NARHC REF).*

☐ ***I understand and acknowledge*** *that the National Association of Rural Health Clinics Research and Education Foundation (NARHC REF) reserves the right to use my name, photograph, and written responses for promotional and educational purposes.*

SIGNATURE **DATE:**

Designated Preceptor/RHC Administrative Contact:

By signing below, I confirm the applicant's active engagement in the program and verify the accuracy of the information provided.

SIGNATURE **DATE:**

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