NEW MEXICO
Department of Health
Public Health Division

MICHELLE LUJAN GRISHAM
Governor

DR. TRACIE C. COLLINS, M.D.
Cabinet Secretary

New Mexico Health Service Corps
Stipend Application

Deadline to application submittal is September 3, 2021 at 5 PM MT.

Please read before applying: If you have a service commitment to a Federal agency, such as the National Health Service Corps, Indian Health Service, or other Federal program, you are not eligible for the New Mexico Health Service Corps (NMHSC) due to program provisions.

ALL sections must be complete.

1. IDENTIFYING DATA

Name: _____
Last First MI

Permanent Address: _____

Mailing Address: _____

Contact Numbers:
1. _____ Cell
2. _____ Home
3. _____ Other – 8:00 am to 5:00 pm Monday to Friday

Email Address: _____
Social Security Number: _____
Date of Birth: _____

What's the longest period of time you have lived in New Mexico? _____

New Applicant? ☐ Yes Renewal? ☐ Yes, when? _____

Optional: The following is optional information that will be helpful to the NMHSC in evaluating its Program should you choose to provide it.

Gender: ☐ Female ☐ Male

Racial/Ethnic Background:
☐ African American/Black
☐ American Indian or Alaskan Native
☐ Asian or Pacific Islander
☐ Latino(a)/Hispanic
☐ White/Non-Hispanic
☐ Other, please specify: _____

2. CAREER CHOICE AND EDUCATION

A. Field of Study and Degree. Indicate your field of study and date you were accepted into the program.

☐ Resident Physician Date: _____
Specify type of residency: _____
☐ Physician Assistant Student Date: _____
☐ Nurse Practitioner Student Date: _____
☐ Nurse Midwifery Student Date: _____
☐ EMT-Paramedic Student Date: _____
☐ Dental Student Date: _____
☐ Dental Hygiene Student Date: _____

B. Educational Institution Presently Attending

Name of School: _____
Division, Branch, or Program of Study: _____
Type of Degree/Certificate Expected: _____
Expected Date of Program Completion: _____

C. Eligible Communities or Practice Sites

If you receive a NMHSC Stipend, you enter into a contract with the Department of Health to provide, once licensed, health services for a minimum of two years (and 1600 hours a year) in an approved, medically underserved area of New Mexico. If you have a special interest or connection with a rural community in New Mexico where you would like to serve after becoming licensed, please indicate those preferences below.

1st Choice
Site Location in County and/or City: _____

Reason for Selection: _____

2nd Choice
Site Location in County and/or City: _____

Reason for Selection: _____

When you are licensed, every effort will be made to assist you with obtaining a position in an approved practice site in the area you prefer. **However, if within a reasonable amount of time after licensure, no position can be found in your preferred areas, you may have to choose from other approved areas or pay back the stipend with a possible penalty of 3 times the amount of the stipend and up to 18% interest per year.**

D. Official transcripts of your last three (3) years of education/training must be included as part of the stipend application, except for MDs and DOs, who must send a copy of their degree and license. Please complete the academic history that apply below:

High School
Name of Institution: _____
City, State, Zip: _____
Date Graduated: _____

College/Advanced Training/EMT Intermediate Training Certificate
Name of Institution: _____
City, State, Zip: _____
Dates of Attendance: _____
Degree/Certificate Attained: ☐ No ☐ Yes, when: _____

College/Advanced Training/Graduate/Medical School Degree/Dental School
Name of Institution: _____
City, State, Zip: _____
Degree/Certificate Attained: ☐ No ☐ Yes, when: _____

3. EMPLOYMENT AND VOLUNTEER ACTIVITIES

Describe experiences and activities that may be relevant to working with population served in the eligible communities or practice sites within New Mexico. You may copy this form and/or attach a resume or curriculum vita that includes the following information for each work or volunteer experience.

Practice Site: _____
Check one: ☐ Paid Position ☐ Volunteer ☐ Student Rotation
Length of Service: _____ Number of Hours Per Week: _____
Job Title: _____
Description of Duties:

Practice Site: _____
Check one: ☐ Paid Position ☐ Volunteer ☐ Student Rotation
Length of Service: _____ Number of Hours Per Week: _____
Job Title: _____
Description of Duties:

4. SELF RECOMMENDATION

Using this page and the space below, please describe your background, career goals, and link those to your desire to serve as a health care professional in underserved areas of New Mexico. Please also include an explanation about how you would benefit from the receipt of stipend funds and why the stipend should be given to you and not another candidate. This essay will allow the NMHSC to fully evaluate your application and counts as 33% of your overall rating during assessment. **NOTE: 4500 character maximum**.

5. REFERENCES

List the names of three (3) references who are not related to you and who can evaluate your academic and/or professional ability and/or interest in working in underserved areas.

APPLICANTS ARE RESPONSIBLE FOR DELIVERING THE REFERENCE REPORT FORMS TO THE REFERENCES LISTED AND ENSURING THAT REFERENCE REPORTS ARE RETURNED AT THE ADDRESS GIVEN ON PAGE 5.

1. Name: _____
   Title: _____
   Relationship to Applicant: _____
   Place of Employment: _____
   Phone Number: _____ Email Address: _____

2. Name: _____
   Title: _____
   Relationship to Applicant: _____
   Place of Employment: _____
   Phone Number: _____ Email Address: _____

3. Name: _____
   Title: _____
   Relationship to Applicant: _____
   Place of Employment: _____
   Phone Number: _____ Email Address: _____

6. CERTIFICATION

This application MUST be signed, dated, and emailed to the address below. Unsigned and incomplete applications will be regard as incomplete and will NOT be processed. False or misleading information may be grounds for denial of a stipend award.[1]

I, _____, certify that all questions and information provided by me on the NMHSC Stipend Application are true and correct to the best of my knowledge and belief. I also authorize verification of all information provided.[2]

Signature: _____ Date: _____

For consideration, ALL application components must be received by **September 3, 2021 at 5:00 PM MT**. Late or incomplete applications will not be reviewed.

Application must be EMAILED to: Eleanor Dominguez at Eleanor.Dominguez@state.nm.us

Transcripts and Reference Report Forms must be MAILED as a hard copy with original signatures directly to: Eleanor Dominguez, NMHSC Program Coordinator, NMDOH/Office of Primary Care and Rural Health, 5301 Central Ave. NE, Suite 800, Albuquerque, NM 87108

If you have any questions, please contact Eleanor Dominguez by email or phone (505) 841-6454.

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[1] If you believe you have a disability as defined by the Americans with Disability Act and require a reasonable accommodation to participate in the NMHSC, please submit a request for accommodation with supporting documentation attached to this application.

[2] All information pertaining to the NMHSC will be maintained at the NM Department of Health, Office of Primary Care and Rural Health, 5301 Central Ave. NE, Suite 800, Albuquerque, NM 87108. This information is confidential and will be used for selection of stipend recipients and monitoring their progress.