New Mexico Health Service Corps
Stipend Application

Application Deadline: September 6, 2024 at 3 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: ________________________________

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 it’s Program should you choose to provide it.

<table>
<thead>
<tr>
<th>Gender:</th>
<th>☐ Female</th>
<th>☐ Male</th>
</tr>
</thead>
</table>

| Racial/Ethnic Background: | ☐ African American/Black | ☐ Latino(a)/Hispanic |
| ☐ American Indian or Alaskan Native | ☐ White/Non-Hispanic |
| ☐ Asian or Pacific Islander | ☐ 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: __________________________________________
Program of Study: _________________________________________
Type of Degree/Certificate Expected: _________________________
Expected Date of Program Completion: _______________________

C. Eligible Practice Sites

☐ I understand that I must contact New Mexico Health Resources (NMHR) who assist NMHSC participants in finding a position at an approved, rural practice site. Location sites that are found through NMHR are automatically DOH-approved by NMHSC.

☐ I understand and acknowledge that if no position can be found after 90 days after licensure, NMHSC participants will have to 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 rural communities or practice sites within New Mexico. You may use this form 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

We know that patients often need health care providers to better understand them as a whole person. This is particularly important among those living in rural areas of New Mexico needing to receive care.
Please describe your desire and commitment to serve as a health care professional in a rural area of New Mexico. Please also describe an experience in which you have contributed to the well-being of a rural, underserved community and the impact/result of your contribution.

Your essay will allow the NMHSC to fully evaluate your application. **NOTE: 500-word count 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 rural areas.

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: ______________________

APPLICANTS ARE RESPONSIBLE FOR ENSURING THAT RECOMMENDATION LETTERS ARE COMPLETED AND SUBMITTED TO THE NMHSC PROGRAM COORDINATOR VIA EMAIL.

6. SELF-CERTIFICATION

This application MUST be signed, dated, and emailed to the address below. Unsigned and incomplete applications will be regarded 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: ______________

It is the applicant’s responsibility to ensure all required supporting documents are received by 3:00 PM MT on September 6, 2024. Failure to submit a complete application package by the deadline will deem the applicant ineligible, and they will not be considered for a NMHSC stipend award.

______________________________

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, 5300 Homestead Rd. NE, Suite 100, Albuquerque, NM 87110. This information is confidential and will be used for selection of stipend recipients and monitoring their progress.