



State of Wisconsin Higher Educational Aids Board

Tony Evers
Governor

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Connie Hutchison, PhD
Executive Secretary

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@wi.gov
Fax: 608-267-2808

For more information, contact:

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