

Indian Health Career Award

Phoenix Indian Medical Center Auxiliary, 4212 North 16th Street, Phoenix, AZ 85016 ☐ 602-263-1576

TO: Counselors of American Indian Students and Interested Persons

FROM: Indian Health Career Award Committee

SUBJECT: Submission of IHCA Applications

The Indian Health Career Awards (IHCA) Program started in 1975 in order to help American Indian students meet small, but significant school needs, as well as, a way to recognize achievement and further motivate student interest in health careers.

The IHCA committee grants awards for Spring and Fall Semesters for full and part-time students. Decisions will be made by factors as proven interest, merit, achievements, recommendations, need and other criteria deemed important by the committee. Applications may be submitted more than once during subsequent academic years.

The IHCA committee is responsible for evaluating the award application, recommendations and accurate records of all income and disbursements. Recipients are urged to send progress reports to the IHCA committee.

Eligibility for Award

- A.** Applicant with a firm commitment to complete studies for a health-related career with Indian Health Service, or Tribal Health Clinics must be enrolled and accepted in an institution of higher learning, as well as, accepted into the health program of their career completing one full semester.
- B.** Applicant must be American Indian or Alaskan Native with documentation of Tribal enrollment.
- C.** First priority is given to Southwestern Tribal members.
- D.** Applicant is required to complete an IHCA Award application.
- E.** Applicant must maintain a minimum of 2.25 G.P.A.

Restrictions: Awards will be flexible up to \$1,000 for full or part-time students according to the discretion of the award committee. After due deliberation and consideration, the committee can make exceptions to restrictions.

Completed applications must be sent to the address above by **July 15th** for the Fall Semester, and **November 15th** for the Spring Semester. The deadline date will be the next business day when the 15th falls on a weekend.

New applicants must complete the application form and attach all the following documents:

1. Copy of acceptance letter into health program from educational institution attending.
2. Complete transcripts from all educational institutions attended. (*High school, college, etc.*) Most recent transcript should show at least one completed semester in health program. (*Student copies or online transcripts acceptable with name auto-printed on each page*)
3. Copy of class schedule for entering semester.
4. Copy of Tribal enrollment documentation.
5. A narrative written on a separate sheet of paper. (*See page 2-E. of IHCA Application for details*)
6. Name of three references from non-related responsible persons who currently know you. All references should be mailed separately. (*Form and address attached*)
7. A head/shoulder picture of applicant not measuring more than 4 x 4.

Returning Applicants

Follow directions printed on the latest letter sent to you from the committee.

Submit Application to:

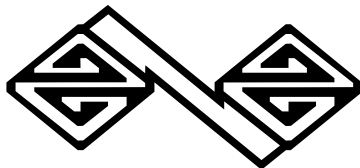
Phoenix Indian Medical Center Auxiliary
Indian Health Career Award
4212 North 16th Street
Phoenix, AZ 85016

Applications must be post-marked no later than:

July 15th – Fall Semester

November 15th – Spring Semester

**Only completed applications will be considered.
Allow six to eight weeks for processing.**



Indian Health Career Award Application

Please fill in all information requested. Please type or print.



Date: _____

A. Personal Information

1. Name: _____ 2. Tribal Affiliation: _____
3. Mailing address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
4. Telephone number: (____) _____ home office cell message
5. Email address: _____
6. Social Security number: _____ 7. Marital status: _____
8. Do you have responsibilities for children and/or other dependents? If yes, please explain:

B. Academic and Technical Background

1. Please list in chronological order the following information about schools and training courses attended, beginning with high school:

<u>School & Location</u>	<u>Major</u>	<u>Dates Attended</u>	<u>Degree/Certificate/Date</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Total credit hours to-date: _____ Grade point average: _____

3. Number of credit hours will you be taking this semester: _____

C. Financial

Please fill out all requested information by semester only.

1. Estimate Income for Semester:	Estimate Expense for Semester:
a. Tribe _____	a. Tuition _____
b. FAFSA _____	b. Fees (Lab, Parking, etc.) _____
c. Parental _____	c. Books _____
d. Spouse _____	d. Room/Rent _____
e. Child Support _____	e. Food _____
f. Employment _____	f. Clothing (uniform, shoes, etc.) _____
g. VA Benefits _____	g. Transportation _____
h. I.H.S. _____	h. Child Care _____
i. Scholarships _____	i. Utilities _____
j. Other (specify) _____	j. Other (specify) _____
 TOTAL _____	 TOTAL _____

2. I am requesting: \$_____ for the semester. The maximum award per semester is \$1,000.

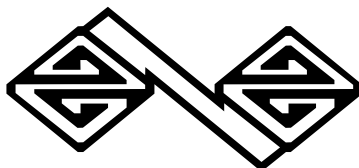
D. Career Goals

- School enrolled/accepted: _____
- Are you a continuing student? Yes No
- Indicate the semester and year for which this award will be used: _____
- What is your career goal? _____
- What degree or accreditation are you seeking? _____
- Date your school term begins: _____

E. Narrative

The IHCA committee is interested in you and your efforts to reach your career goal(s). On a separate sheet of paper, briefly describe the following:

- Reason you are applying for particular source.
- Any practical experience in your chosen career.
- How and where you hope to pursue your career.
- Community service/volunteering experiences.
- Other special skills and abilities you have to enhance your career.



F. References

Please give names and addresses of three non-related responsible persons in a health field who know of your character, work history and educational background (i.e., employers, teachers, counselors, etc.). Give each a Personal Recommendation form to fill out and mail back in a separate envelope; form is attached.

Name _____
Address _____
City _____ State _____ Zip _____
Phone (____) _____
Email _____

Name _____
Address _____
City _____ State _____ Zip _____
Phone (____) _____
Email _____

Name _____
Address _____
City _____ State _____ Zip _____
Phone (____) _____
Email _____

The information provided is complete and accurate to the best of my knowledge. I understand and agree that this award is to be used exclusively for the purpose of furthering my career in a health program at an accredited institution.

Signature of Applicant

date

Mail completed application to:
Phoenix Indian Medical Center Auxiliary
Indian Health Career Award Committee
4212 North 16th Street
Phoenix, AZ 85016

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