Western Oregon UNIVERSITY

___XX___ 1st Year of Training
_____ 2nd Year of Training

RSA SCHOLARSHIP AGREEMENT
Tuition/Stipend Scholarship Acceptance Form
Academic Year 2017-2018

This Scholarship Agreement is entered into on the date noted below in compliance with Federal regulations at Title 34 of the CFR (Code of Federal Regulations), Part 386 related to the Long-Term Training Program funded by the Rehabilitation Services Administration of the U.S. Department of Education. The Federal regulations noted above in this Agreement and the RSA Long-Term Training Scholarship Manual have been made available to me by the institution that awarded the scholarship funds. An official of the applicable institution, by signing this Agreement, acknowledges that the terms and conditions of the scholarship have been fully disclosed to the scholar by providing all applicable information.

I, _____, agree to abide by the stipulations noted below as conditions of receipt of the scholarship for training in the *Rehabilitation and Mental Health Counseling* program at *Western Oregon University*.

My receipt of these scholarship funds is predicated upon the expectation that I will maintain or seek employment only in State rehabilitation agency or in a nonprofit rehabilitation agency, professional corporation, professional practice group, or related agency providing services to individuals with disabilities under an agreement with a designated State agency. Under the terms of the Long-Term Training Program, scholarship funds include all disbursements or credits for student stipends, tuition and fees, and student travel in conjunction with training assignments.

Therefore, as a designated Long-Term Training scholar, I agree to

(1) complete internship (18 credits) in a state vocational rehabilitation agency or Commission for the Blind agency; exceptions to this requirement can only be approved from RSA.

(2) maintain employment --

(a) in a nonprofit rehabilitation agency or related agency or in a State rehabilitation agency or related agency, including a professional corporation or professional practice group through which the agency has a service arrangement with the designated State agency;

(b) on a full- or part-time basis; and

(c) for a period of not less than the full-time equivalent of two years for each academic year for which scholarship assistance was received, within a period, beginning after I

complete the training for which the scholarship was awarded, of not more than the sum of the number of years required in this paragraph and two additional years; and

(3) repay all or part of any scholarship received, plus interest, if I do not fulfill the requirements of paragraph (1) of this agreement (immediately above), except as the Secretary of Education by regulations may provide for repayment exceptions and deferrals.

(4) The employment obligation as applied to a part-time scholar will be based on the accumulated academic years of training for which the scholarship is received.

(5) Until I have satisfied the employment obligation described above, I will immediately inform the institution which awarded the scholarship of any change of name, address, or employment status and will document employment satisfying the terms of the agreement.

(6) Subject to the provisions in 34 CFR 386.41 of the Federal regulations, regarding a deferral or exception, if I enter repayment status under 34 CFR 386.43(e), the amount of the scholarship that has not been retired through eligible employment will constitute a debt owed to the United States that --

(a) will be repaid by me, including interest and costs of collection as provided in 34 CFR 386.43; and

(b) may be collected by the Secretary of Education in accordance with 34 CFR Part 30, in the case of a failure to meet the obligation of 34 CFR 386.43.

_____ _____
(Signature of Scholar) (Date)

_____
(Social Security Number of Scholar)**

_____ _____
Signature of Project Director or Other Grantee Official) (Date)

**The Student is REQUIRED to provide his/her Social Security Number for collection purposes

Western Oregon UNIVERSITY

WESTERN OREGON UNIVERSITY
REHABILITATION AND MENTAL HEALTH COUNSELING
Student Information Form
(To be completed by scholarship recipient at program entrance and exit)

PRINT Name_____ Social Security Number_____
Last First MI

Local Address:

Street_____

City_____

State_____ Zip_____

Telephone Number_____

Permanent Address: (if different than local)

Street_____

City_____

State_____ Zip_____

Telephone Number_____

WOU E-mail_____

Personal E-mail_____

Date of Birth_____ Driver's License Number_____ State_____

Date (or expected date) of Graduation _____

****PARENT OR GUARDIAN**: **PLEASE COMPLETE THIS SECTION EVEN IF YOU ARE AN INDEPENDENT STUDENT**

Name_____ Telephone Number_____E-mail_____

Street_____City_____ State_____ Zip_____

****TWO PEOPLE WHO WILL ALWAYS KNOW YOUR ADDRESS:**

Name_____ Telephone Number_____E-mail_____

Street_____City_____ State_____ Zip_____

Name_____ Telephone Number_____E-mail_____

Street_____City_____ State_____ Zip_____

*** We will contact them only if we are unable to reach you or need to get information to you. By listing them, you are giving us permission to contact.*

_____ _____
Your Signature Date

2/16