

# CAREER/OCCUPATIONAL-BASED SCHOLARSHIP PROGRAMS

## Annual Service Obligation Questionnaire



**Failure to complete and return this questionnaire by the deadline on the enclosed letter may place your scholarship/grant into repayment status. Complete only the sections that pertain to your situation and submit this form to the Office of Student Financial Assistance by email to [careerbased.mhec@maryland.gov](mailto:careerbased.mhec@maryland.gov).**

### SECTION A: Recipient Information

1. MHEC ID: \_\_\_\_\_ Last Four Digits of Social Security: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
2. Last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_
3. Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
4. Home phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_
5. Name of College \_\_\_\_\_  
Graduated from: \_\_\_\_\_ Graduation Date: \_\_\_\_\_ Degree Received: \_\_\_\_\_  
*(i.e B.S. in Biology)*

### SECTION B: Select the Situation that Best Applies to You

**I am seeking to postpone my service or repayment for one of the following reasons:**

Enrolled in School (**Submit documentation of your enrollment or Complete Section C**)

I am not currently working because I am on a temporary leave of absence or have a disability, which prevents me from working (**Submit documentation from your employer or physician as applicable**)

I have been unable to secure employment for a period not to exceed twelve (12) months due to the care required by a spouse or child who is disabled. (**Submit documentation from physician.**)

I have never received deferment of my service and am actively seeking employment for a period not to exceed twelve (12) months beyond my date of graduation.

I (or my spouse) have been assigned military duty outside of the State of Maryland (Please include a copy of themilitary orders). Name/Relationship of the person in the military: \_\_\_\_\_  
(**Submit documentation of military orders**)

Other (**Please include letter of explanation and supporting documentation**)

**I must begin repayment of my scholarship/grant (i.e. I am not employed in the required field and/or I am not working in Maryland)**

**I am working full-time in the State of Maryland. (Complete Section D)**

**SECTION C: Registrar Certification Form**

This section must be completed by the college/university and should **only** be completed if the recipient is requesting deferment due to continuing enrollment. The student is responsible for returning completed form.

I certify that the student listed below is enrolled for the current semester at this college/university:

1. Last Four Digits of Social Security Number: \_\_\_\_\_ Date of birth: \_\_\_\_\_

2. Last name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

3. Name of College: \_\_\_\_\_ Semester Enrolled: \_\_\_\_\_

4. Enrollment status:  Full-time (12+ credits for undergraduate; 9+ credits for graduate)  
 Part-time (6-11 credits for undergraduate; 6-8 credits for graduate)  
 Less than 6 credits (may result in repayment)

5. \_\_\_\_\_  
Please affix official college/university seal here

6. \_\_\_\_\_  
Signature of certifying official (*Electronic Signature Acceptable; Typed Signature Prohibited*) Date

7. \_\_\_\_\_  
Printed name of official Telephone

8. \_\_\_\_\_  
Title of Certifying Official Email

**SECTION D - Employment/Service Obligation Information:**

**NOTE: An Employee Information Release Form must be completed for each employer who is to be considered for service obligation fulfillment.\***

1. Last Four Digits of Social Security Number: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
2. Last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_

**Employee Information Release Statement**

I hereby authorize my employer to provide the information requested by the Maryland Higher Education Commission, Office of Student Financial Assistance. I also release my employer from any liability for the consequences of this release.

Signature of recipient \_\_\_\_\_ Date: \_\_\_\_\_  
*(Electronic Signature Acceptable; Typed Signature Prohibited)*

**Employment Information (To be completed by the recipient of the scholarship)**

1. Name of Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone number: \_\_\_\_\_ Email: \_\_\_\_\_
2. Job title: \_\_\_\_\_
3. Employment status:            Full-time            Part-time
4. Dates of employment: from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

*\* You may make as many copies of this form as needed.*

**Recipient Certification:**

I certify that the information provided by me in the questionnaire is true and complete to the best of my knowledge. I also agree to inform the Office of Student Financial Assistance, in writing, immediately upon the termination of my claimed status, or if there are any changes to name, address, place of employment or college/university study.

Signature of recipient *(Electronic Signature Acceptable; Typed Signature Prohibited)* \_\_\_\_\_ Date \_\_\_\_\_