

Section A. Please answer these general questions.

1. Tell us why you are submitting this application. (You may check more than one box.)

- Initial Certification.** This is a request for initial approval to participate in federal student financial aid programs and to be initially designated as an eligible institution for other Higher Education Amendments (HEA) programs.
- Change in institutional ownership or structure.** This is a request to participate in federal student financial aid programs and to be designated as an eligible institution for other HEA programs following a change in institutional ownership or structure.
- Check here if requesting a preacquisition review.
- Recertification.** This is a request to continue to participate in federal student financial aid programs and to continue to be designated as an eligible institution for other HEA programs either in response to a recertification notice from us or because your institution's Program Participation Agreement (PPA) will expire soon.
- Designation as an eligible institution.** This is a request to be designated as an eligible institution so that your students may receive deferments under federal student loan programs or so that your institution may apply to participate in federal HEA programs other than Title IV student financial aid programs, including the Hope and Lifetime Learning Tax Credits.
- Reinstatement.** This is a request to be reinstated to participate in federal student financial aid programs and/or to be redesignated as an eligible institution for other HEA programs.
- Update/Other** (specify)

2. What is the name of your institution?

3a. Do you have another name such as a trade name or a d/b/a name, under which you legally do business as a postsecondary educational institution?

- Yes No

If yes, what is that name?

3b. During the last 4 years, have you had another name that you have not previously reported to the Department of Education?

Yes No

If yes, what was that name?

4. Check here if you are an institution resulting from a merger in the past four years, and give the names and OPEID numbers of the former (pre-merger) institutions.

5. What are the first 6 digits of your 8-digit OPE ID number? The final 2 digits already are entered for you.

Check here if you are an initial applicant and do not have an OPE ID number, and go to Question 6.

Current OPE ID (or former OPE ID if seeking reinstatement)

Check here if you are an institution resulting from a merger in the past four years, and give the OPE ID numbers of the former (pre-merger) institutions.

6a. What is your 9-digit Taxpayer Identification Number (TIN) assigned by the IRS?

Check here if you are an institution resulting from a merger in the past four years, and give the TINs of the former (pre-merger) institutions.

6b. What is your 9-digit DUNS number?

7. What was your most recently completed award year?

Beginning date:

Ending date:

8. What is your current award year?

Beginning date:

Ending date:

9. Does your institution have a web site (or home page) on the Internet?

Yes No

If yes, list the electronic address (URL).

10. Who is your chief executive officer (CEO)/president/chancellor?

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

Job title

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

11. Who is your chief fiscal officer/financial officer?

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

Job title

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

12. Who is your chief financial aid director?

This must be a capable individual designated to be responsible for administering all the Title IV, HEA programs and coordinating those programs with the institution's other Federal and non-Federal programs of student financial assistance. (See 34 CFR 668.16)

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr)

Job title

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

13. To whom do you wish us to send publications (such as the FSA Handbook) and printed communications concerning federal student financial aid?

Same person as in Question 10.

Same person as in Question 12.

If neither of these people, complete the information below.

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

Job title

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

14. Whom should we contact at your institution if we have questions about information in this form.(Note: If there is someone you wish us to contact outside of your institution, you may enter them in question 70.)

- Same person as in Question 10.
- Same person as in Question 12.
- Same person as in Question 13.

If none of these people, complete the information below.

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

Job title

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Section B. Please tell us about your accreditation and state authorization to provide postsecondary education.

Check here if you are a foreign institution, and **go to Section C.**

15. What is your accrediting agency? (Complete **a.** if you have institution-wide accreditation; complete **b.** if you do **not** have institution-wide accreditation.)

- a. If you have institution-wide accreditation, provide the following information for each agency.

If more than one accrediting agency provides accreditation, designate the one you wish us to use in determining your eligibility and continued eligibility.

Abbreviation of accrediting agency (*A list of abbreviations accompanies this application.*)

You must include a copy of your current letter of accreditation.

- What year did your accrediting agency last accredit you?

- For how many years is this accreditation granted?

- c. If you do **not** have institution-wide accreditation, provide the following information for each accrediting agency that either accredits a program that is currently eligible or for which you are seeking eligibility. (This includes programs such as a hospital-based nursing program or radiologic technology program.)

Abbreviation of accrediting agency (*A list of abbreviations accompanies this application.*)

You must include a copy of your current letter of accreditation.

- What year did your accrediting agency last accredit you?

- For how many years is this accreditation granted?

Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

16. Check here if you do not offer a flight program, and go to Question 17.

If you offer a flight program, provide your certification number from the U.S. Federal Aviation Administration (FAA).

Number

Date FAA certification expires

17. What state agencies authorize or license you to provide postsecondary educational programs? (For this question, do not include educational programs that are provided at “distance learning” sites.)

- a. Check here if you are a public institution and do not provide at least 50% of an educational program outside your state, and go to Section C.
- b. Check here if you are a public institution and you do provide at least 50% of an educational program outside your state, and list (for each state other than your “home” state) each state agency that licenses you, or otherwise provides you with legal authority, to provide postsecondary educational programs.
- c. Check here if you are a private institution, and list each state agency that licenses you, or otherwise provides you with legal authority, to provide postsecondary educational programs.
- d. Check here if you or your programs are not required to be authorized or licensed by a state agency, and include a copy of the basis for that determination.

Name of agency

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

You must include a copy of your current state license(s) or other state authorization(s) and/or exemption(s).

Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Section C. Please describe your institutional control and structure.

18. Check your type of institutional structure (check one).

Public institution

Private nonprofit 501(c)(3) institution

You must include a copy of your 501(c)(3) designation from the IRS.

For-profit institution

Foreign institution (check one)

Foreign Public institution

Foreign Private nonprofit institution (Note: a foreign private nonprofit institution is one that is owned and operated only by one or more nonprofit corporations or associations, **and** either its home country tax authority recognized by the Secretary of Education has designated the institution as a nonprofit educational institution **or** if no tax authority in the home country is recognized by the Secretary of Education, the foreign institution demonstrates to the satisfaction of the Secretary that it is a nonprofit educational institution)

You must include a copy of your nonprofit designation status and a certified English translation of your nonprofit designation status.

Foreign For-profit institution (Note: Foreign graduate medical schools, foreign veterinary schools whose students complete their clinical training at an approved veterinary school in the U.S., and foreign nursing schools whose students complete clinical training at an approved U.S. hospital or accredited school of nursing in the U.S., and whose students also receive a degree in nursing from an accredited school of nursing in the U.S. are the only foreign for-profit institution eligible to apply to participate in federal student financial aid programs.)

19. Check here if this is a request for initial certification, and go to Question 20.

For all other institutions, since you were last certified to participate in federal student financial aid programs, has your institutional structure checked in Question 18 changed?

Yes No

If yes, give the date of the change.

20. Check here if you are a public institution, and **go to Section D.**

Check here if you are not a public institution, and list the names of your board of trustees or your board of directors.

Check here if you have a board of trustees.

Check here if you have a board of directors.

Check here if you have more than 10 on your board, and list only the board's executive committee and provide the name of a contact person in Question 21.

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

21. If you provide only the board's executive committee in Question 20, tell us who is the appropriate person to contact for further information about your board (for example, the board's recording secretary)?

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

Job title

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

 ext:

Fax number (including area code)

 ext:

E-mail address (if applicable)

Section D. If you are a for-profit institution, or are a not-for-profit institution with a change in control, please answer these questions. (This includes for-profit foreign graduate medical, veterinary, and nursing schools and foreign not-for-profit institutions with a change in control.)

Check here if you are **not** a for-profit institution, or are a not-for-profit institution that has not undergone a change in control and go to Section E.

22. Check the type of ownership you have (check one).

Corporation - publicly traded

Corporation - not publicly traded

Partnership

Proprietorship

23. If you are a corporation, give the name and address of the contact person (sometimes known as the “registered agent”) within the state or foreign country where you are incorporated.

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

Job title

Company name, if applicable

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

24. Provide the following information for each person or entity that directly or indirectly owns a 25% or greater interest in your institution.

a. The owner or person is (check one):

- a corporation (complete **b.** and **c.**)
 - Publicly traded - Provide the stock exchange trading symbol _____
 - Closely held corporation
 - Subchapter S Corporation
 - Limited Liability Company
 - Other, identify _____

b. an unincorporated business entity (such as a partnership or trust) (complete **b.** and **c.**)

- General partner/partnership
- Limited liability
- partnership Proprietorship
- Voting trust
- Other, identify _____

an individual (complete d.)

Name of corporation or other entity

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Percentage of ownership

Date ownership began

TIN

Identify the state or country in which you are incorporated.

- c. List the following information for each person or entity that directly or indirectly owns a 25% or greater interest in this corporate owner or entity:

Name of owner

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Home address

City

State (or province) and zip (and country, if outside the U.S.)

Percentage of ownership

Date ownership began

SSN of owner (required)

Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

- d. If the owner is an individual (who holds ownership individually, or together with one or more members of his or her family, or in combination with others, such as a voting trust) provide the following information.

Name of owner

First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

Business street address and home address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Percentage of ownership

Date ownership began

SSN of owner (required)

Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

25. Has a person or entity listed in Question 24 or a member of that person's family or a director of your institution owned 25% or more or held a position listed below of another institution that is now participating in or ever participated in federal student financial aid programs or of a third-party servicer listed in Question 58?

The ownership could be:

- individual, or
- held by one or more family members, or
- in combination with others, such as a voting trust.

The position held at another institution could be any of the following:

- member of the board of directors, or
- chief executive officer, or
- other executive officer, general partner or director of the institution or servicer.

Yes

No

If yes, what is the name of the owner (either the name of a person or an entity) or the director?
(If a person, include prefix, such as Mr., Ms., Dr.)

If applicable, what is the name of the third-party servicer that is or was owned?

If applicable, what is the name of the institution that is or was owned?

If applicable, what is the current or former OPE ID of this institution?

Is there any liability currently owed to the Department that was established during the period of ownership or position held? (If yes, please explain in Section K, Question 69)

Yes

No

Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Section E. Please provide the following information for each educational program that you are requesting be eligible to participate in federal student financial aid programs.

26. Please check each box that describes the educational programs that you provide as of the date you submit this application or that you will provide during the current award year. **Provide information only on programs that you wish to be eligible for federal student financial aid.** (You may check more than one box.)

Note: The institution must be able to demonstrate a reasonable relationship between the length of the program and the entry-level requirement for the recognized occupation for which the program prepares the student. The Secretary considers the relationship to be reasonable if the number of clock hours provided in the program does not exceed by more than 50 percent the minimum number of clock hours required for training in the recognized occupation for which the program prepares the student, as established by the State in which the program is offered, if the State has established such a requirement, or as established by any Federal agency. If the program exceeds by more than 50 percent of the State or Federal minimum number of clock hours, please explain in Section K, Question 69.

Note: Post-baccalaureate students pursuing prerequisite coursework (such as prerequisite courses for medical school) have their eligibility determined on the basis of *student* eligibility for federal student financial aid criteria rather than *program* eligibility criteria. Therefore, these types of programs are not included here.

- a. associate degree programs
- b. bachelor's degree programs
- c. master's degree programs or doctoral degree programs
- d. first professional degree programs

Do you measure student's progress in any of these degree programs by direct assessment instead of credit or clock hours?

Yes No

- e. graduate or professional programs that
- do not lead to a post-baccalaureate degree,
 - are at least 10 weeks, and
 - provide at least 8 semester or trimester credit hours, 12 quarter credit hours, or 300 clock hours of instruction.
 - prepare students for gainful employment in a recognized occupation
- f. two-academic-year transfer programs (*see glossary*)
- g. undergraduate programs that
- lead to a certificate or other recognized educational credential,
 - prepare students for gainful employment in a recognized occupation,
 - are at least 15 weeks, and
 - provide at least 16 semester or trimester credit hours, 24 quarter credit hours, or 600 clock hours of instruction.

- h. undergraduate programs that
- lead to a certificate or other recognized educational credential,
 - prepare students for gainful employment in a recognized occupation,
 - are at least 10 weeks,
 - provide at least 8 semester or trimester credit hours, 12 quarter credit hours, or 300 clock hours of instruction,
- AND**
- require an enrolling regular student to have an associate degree or higher degree.
- i. undergraduate programs that
- lead to a certificate or other recognized educational credential,
 - prepare students for gainful employment in a recognized occupation,
 - are at least 10 weeks,
 - provide at least 300 but not more than 599 clock hours of instruction,
 - do not exceed by more than 50% the minimum number of clock hours established by the state for such training programs, and
 - have been provided for at least one year.
- j. Post-baccalaureate teacher certification program necessary to become a teacher in an elementary or secondary school in that state. Please refer to the glossary for more information about this program type.
- k. Comprehensive Transition and Postsecondary Program (for students with intellectual disabilities - please refer to 34 C.F.R. 668.231 for information about the requirements of this program)

Check here if you award an associate degree, bachelor's degree, or higher degree to all your students who successfully complete any of your programs, and go to Question 28.

If you checked boxes e., g., h., or i. in Question 26, provide the following information.

- a. If you checked box e. in Question 26, list the following information for each program.

Name of program

CIP code (*A list of CIP codes accompanies this application.*)

Number of weeks

Clock hours (number of hours) of instruction

Number of credit hours

Type (check one)

semester credit hours trimester credit hours quarter credit hours

Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

b. If you checked boxes g. or h. in Question 26, list the following information for each program.

Name of program

CIP code (*A list of CIP codes accompanies this application.*)

Date first provided

Number of weeks

Clock hours (number of hours) of instruction (*This is required information.*)

If you offer the program in credit hours,

Number of credit hours

Type (check one)

semester credit hours trimester credit hours quarter credit hours

Is each course within the program acceptable for full credit toward your associate degree or higher degree.

Yes No

Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

c. If you checked box **i.** in Question 26, list the following information for each program.

Name of program

CIP code (*A list of CIP codes accompanies this application.*)

Date first provided

Number of weeks

Clock hours (number of hours) of instruction.

Maximum number of clock hours authorized by the state licensing agency

Completion rate*

Placement rate*

*Provide the completion rate and the placement rate for your most recently completed award year. (Instructions on how to calculate the completion rate are found in 34 CFR 668.8(f). Instructions on how to calculate the placement rate are found in 34 CFR 668.8(g).)

Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

d. If you checked box **k.** in Question 26, list the following information for each program.

Name of program

CIP code (A list of CIP codes accompanies this application.)

Date first provided

Number of weeks

Clock hours (number of hours) of instruction (This is required information.)

If you offer the program in credit hours,

Number of credit hours

Type (check one)

semester credit hours trimester credit hours quarter credit hours

Is each course within the program acceptable for full credit toward your associate degree or higher degree.

Yes No

*If not previously provided, the institution must provide a detailed description of this Comprehensive Transition and Postsecondary Program addressing all of the components of the program as defined in 34 C.F.R. 668.231. The institution must send this information as a pdf attachment to FSA_PEPS@ed.gov.

Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

28. Do you contract with an organization or ineligible institution (such as internship, externships, practicum in nursing, midwifery, medical technician, etc.) to provide more than 25% of any educational program?

Note: If you contract more than 50% of the program to an organization or ineligible institution, the program is not eligible for Title IV.

Yes No

If yes, provide the following information.

a. Name of program

Name of organization or ineligible institution

Corporation name, if applicable

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Former OPE ID number of the other institution, if applicable

What percent of the program is contracted out?

You must include a copy of the approval from your accrediting agency for contracting this program.

- b. Check here if any owner or person listed in Question 24 or Question 25 directly or indirectly

- owns or controls 25% or more of the ineligible institution

or

- serves as a director or as an executive officer of the ineligible institution.

What is the name of this owner or person?

- c. Did the ineligible institution withdraw from participating in federal student financial aid programs under a termination, show cause, suspension, or similar type of proceeding initiated by its state licensing agency, accrediting agency, guarantor, or the U.S. Secretary of Education?

Yes

No

Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

New substitute Question 28 for foreign institutions only:

Report all educational programs offered by your institution that are:

- for purposes of students who receive Title IV, HEA programs funds through your institution, offered through an arrangement (including, but not limited, study-abroad agreements, contractual agreements, consortium agreements, twinning programs, dual-degree programs, joint-degree program, dual-enrollment programs) with another organization or institution that is not eligible to participate in the U.S. Federal Student Aid Programs

or

- for purposes of students who receive Title IV, HEA programs funds through your institution, offered at a location in the United States (except for medical, veterinary or nursing clinical training) through an arrangement (including, but not limited, study-abroad agreements, contractual agreements, consortium agreements, twinning programs, dual-degree programs, joint-degree program, dual-enrollment programs) with another institution or organization to provide any portion of your educational program(s) at a location in the United States.

or

- provided to students who receive Title IV, HEA program funds through your institution at a location in the United States under your institution's ownership or administrative control (except for state approved clinical training for medicine, veterinary medicine, or nursing programs).

Name of Educational Program: [_____]

This educational program is (check all that apply):

check here if the program is offered through an arrangement (including, but not limited, study-abroad agreements, contractual agreements, consortium agreements, twinning programs, dual-degree programs, joint-degree program, dual-enrollment programs) with another organization or institution that is not eligible to participate in the U.S. Federal Student Aid Programs

check here if the program is offered at a location in the United States (except for medical, veterinary or nursing clinical training) through an arrangement (including, but not limited, study-abroad agreements, contractual agreements, consortium agreements, twinning programs, dual-degree programs, joint-degree program, dual-enrollment programs) with another institution or organization to provide any portion of your educational program(s) at a location in the United States.

check here if the program is provided to students who receive Title IV, HEA program funds through your institution at a location in the United States under your institution's ownership or

administrative control (except for state approved clinical training for medicine, veterinary medicine, or nursing programs).

Location(s) where students receive instruction for this educational program

Business Street Address 1

Business Street Address 2

City

State/Territory/ Foreign Province

Zip Code + / Postal Code

Country

Contact person name, phone number and email address at this location

Check here if you need space to identify more than one location for this educational program and continue on a separate sheet. On the separate sheet, identify the name of the educational program repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Name of Institution or Organization

that provides the program

OPEID of the institution (if applicable)

Address of the partner institution

Business Street Address 1

Business Street Address 2

City

State/Territory/ Foreign Province

Zip Code + / Postal Code

Country

Contact person name, phone number and email for the educational partner

Check here if you need space to identify more than one institution or organization for this educational program and continue on a separate sheet. On the separate sheet, identify the name of the educational program, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Check here if you need space to identify more than one educational program and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Section F. Please tell us about your locations.

29. What is your principal location?

Name of location

Business street address

City

County

State (or province) and zip+4 (and country, if outside the U.S.)

30. Provide the following information for any of your locations (other than your principal location) that meet any one of these three criteria and at which you provide educational programs to students whom you wish to participate in federal student financial aid programs:

- It is a location where students could complete 50% or more of an educational program that you offer during the current award year.

or

- It is a location where students could complete at least 50% of an educational program over a two-year period (consisting of the current award year and the most recently completed award year).

or

- It is a location where you provide any educational programs if, during the past two-year period (consisting of the current award year and the most recently completed award year), you told students that they could complete at least 50% of any educational programs there.

Name of location

Business street address

City

County

State (or province) and zip+4 (and country, if outside the U.S.)

OPE ID number of location *or* if no OPE ID number, check here

DUNS number

Would you like to receive mailings from the Department at this location?

Yes No

Check here if the mailing address is different from the address above, and provide the mailing address below.

Mailing address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

New Question for Domestic School

[] Check here if your educational enterprise enrolls students who are eligible to receive Title IV, HEA program funds to attend a location outside of a State AND report the following information for your entire educational enterprise:

(**Note:** for the purpose of this question, an “educational enterprise” consists of two or more locations offering all or part of an educational program that are directly or indirectly under common ownership.)

Number of students who currently attend the U.S. location(s) of your educational enterprise and who are currently eligible to receive Title IV, HEA program funds

Number of students who currently attend the foreign location(s) of your educational enterprise and who are currently eligible to receive title IV, HEA program funds

If you are not reporting your foreign location(s) as an additional location in Question 30, report your educational enterprise's foreign location(s) below.

Name of foreign location

Business street address

City

Province/Territory

Country and Postal Code

OPE ID number of foreign location *or* if no OPE ID number, check here

- Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

For foreign schools only: Identify below any educational sites not listed elsewhere in this application where students may receive training or instruction through an educational program offered by your institution (report locations where students receive classroom instruction, lecture, internships, clinical training, externship, research, special studies, or practicum instruction, including instruction provided through current study abroad agreements, dual degree or joint degree program agreements, or other exchange agreements.)

Note: If you are applying for approval of your foreign medical school, foreign veterinary school, or foreign nursing school, do not report your medical, veterinary, or nursing instructional sites in this section. You will report medical, veterinary, and nursing instructional sites elsewhere in this application.

Educational Site Name: [_____]

Is 50% or more of any of your educational program(s) offered at this educational site?

Yes or No

Provide the address for this Educational Location

Business Street Address 1: [_____]

Business Street Address 2: [_____]

Business Street Address 3: [_____]

City: [_____]

State/Territory: [_____]

32b. For the most recently completed award year, were 50% or more of your regular students enrolled in correspondence courses? (See 34 CFR 600.7, and 668.38)

Yes No

33. For the most recently completed award year, were more than 50% of your regular students ability-to-benefit students? (See 34 CFR 600.7 and 668.32)

Note: Do not include students who are being educated at your institution under a specific contract with federal, state, or local governments for training purposes (such as most contracts under the Job Training Partnership Act)

Yes No

34. During the most recently completed award year, were more than 25% of your regular students incarcerated? (See 34 CFR 600.2, 600.7, and 668.32)

Yes No

Section H. Please complete this section if this is an initial application or you were certified but you have a change in your ownership or structure or you are seeking reinstatement.

Check here if this is **not** an initial application or a change in ownership or structure or for reinstatement, and **go to Section I.**

Note: Here “change in ownership or structure” refers to a change in ownership, conversion to or from a non-profit institution, or a merger of two or more institutions.

If you acquired the institution *or* if the institution is the result of a merger of two or more former institutions, you will be liable for any debts incurred by your predecessors under federal student financial aid programs.

35. Tell us why you are completing this section.

This is an initial application and you are a new institution *without* a prior history. Enter your start date and answer Questions 36, 37, and 38, then **go to Section I.**

- This is an initial application and you are a new institution *with* a prior history (for example, you have been in operation for one or two years). Answer **all** the questions in this section.

Tell us on what date you were both legally authorized to provide and began continuously providing the education or training program(s) for which you are seeking eligibility.

Start Date

Note: If you are a for-profit institution or if you offer only a program(s) of less than one academic year, you must have been in existence for at least two years to be eligible to participate in federal student financial aid programs. (See 34 CFR 600.5 and 600.6)

- You are an institution with a change in your ownership. Answer Questions 36, 37, and 38, then **go to Section I.**
- You are an institution that converted to a not-for-profit institution. Answer Questions 36, 37, and 38, then **go to Section I.**
- You are an institution that converted to a for-profit institution. Answer Questions 36, 37, and 38 then **go to Section I.**
- You are an institution resulting from a merger in the past four years. Answer Questions 36, 37, and 38 about the newly formed institution, then **go to Section I.**
- You are an institution seeking reinstatement. Answer all the questions in this section.

36. How many full-time equivalent (FTE) financial aid staff members do you have? Administrative, counselors, or other professionals

Clerical FTE

FTE

37. Indicate all of the federal student financial aid programs in which you are seeking approval to participate. (**Note:** Foreign institutions, including foreign graduate medical schools, may apply only for the William D. Ford Federal Direct Loan Program (Direct Loan Program))

- Federal Pell Grant Program**
- Federal Perkins Loan Program**
- Federal Supplemental Educational Opportunity Grant (FSEOG) Program**

Federal Work-Study (FWS) Program

Indicate specific programs within FWS for which you are seeking approval

- to participate. Federal Work-Study-regular or general
- Job Location and Development (JLD)
- Program Private-Sector Employment

Federal Family Education Loan (FFEL) Program- No Longer Available

(formerly called the Guaranteed Student Loan Program)

Indicate specific programs within FFEL for which you are seeking approval to

- participate. Federal Stafford Loan Program (subsidized)
- Federal Stafford Loan Program
- (unsubsidized) Federal PLUS Loan Program

William D. Ford Federal Direct Loan Program (Direct Loan Program)

Indicate specific programs within the Direct Loan Program for which you are seeking approval to participate.

- Federal Direct Loan Program (subsidized)
- Federal Direct Loan Program (unsubsidized)
- Federal Direct PLUS Loan Program

38. Do you anticipate an increase of 10% or more in your student body in the next award year?

- Yes No

If yes, how many regular students do you estimate would be eligible to receive federal student financial aid for the remainder of the current award year and each of the next two award years if you become eligible to participate in federal student financial aid programs?

Estimated number for the remainder of the current award year

Estimated number for the next award year

Estimated number for the award year following the next award year

39. Provide the following information about your regular students. (If a student drops out and then reenrolls, count the student each time.)
- a. How many regular students were enrolled at your institution during your most recently completed award year?
-
- b. How many regular students in **a.** dropped out during the 100% refund period during your most recently completed award year?
-
- c. How many regular students in **a.** dropped out after the 100% refund period during your most recently completed award year?
-

40. If you provide vocational programs, list all such educational programs (not classes):

- that you have provided continuously for at least 24 months

and

- for which you would like regular students to be eligible for federal student financial aid.

Name of program

- Check here if you need space to give more answers and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Section I. If you are a foreign institution, please complete this section. (This includes foreign graduate medical schools, foreign veterinary schools, and foreign nursing schools.)

- Check here if you are not a foreign institution, and go to Section J.

Note: If you are a foreign institution, you must **include a copy of your most recent catalog and a certified English translation (see glossary) of all sections dealing with degrees and programs provided at your institution.**

41. Do you admit as regular students only people who have a credential of secondary school completion or its recognized equivalent?

Yes

No

42. In the country where you are located, are you legally authorized to provide an educational program beyond the secondary school level?

Yes No

You must include a copy of your legal authorization and its certified English translation.

If yes, what is the name and address of the agency or ministry within the country that enforces this authority?

Name of agency

Business street address

City

Country

Telephone number (Complete international telephone number)

 ext:

Fax number (including area code)

 ext:

E-mail address (if applicable)

43. Are you legally authorized to award a degree that is equivalent to an associate, baccalaureate, graduate, or professional degree awarded in the United States?

Yes No

You must include a copy of your legal authorization and its certified English translation.

44. Do you provide an educational program that is at least a two-academic-year program acceptable for full credit toward the equivalent of a baccalaureate degree awarded in the United States?

Yes No

45. Do you provide any educational programs that meet all three of these criteria?
- The program is equivalent to at least a one-academic-year training program in the United States.
- and*
- The program leads to a certificate, degree, or other educational credential that is equivalent to one offered in the United States.
- and*
- The program prepares students for gainful employment in an occupation that is equivalent to one in the United States.

Yes No

46. Do you have administrative offices and/or recruiting offices in the United States that represent you?

Yes No

If yes, provide the following information.

Name of office

Business street address

City

State and zip+4

Telephone number (including area code)

 ext:

Fax number (including area code)

 ext:

E-mail address (if applicable)

Name of contact person at the office:

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

- Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.
- Check here if you are a foreign institution that offers any educational program that prepares students to practice osteopathic or allopathic medicine, veterinary medicine, or nursing, and identify each type of program that your institution offers:
- Osteopathic or Allopathic Medicine
 - Veterinary Medicine
 - Nursing
- Check here if you are a foreign institution does not wish to apply for approval for your foreign graduate medical school, foreign veterinary school, or foreign nursing school, **or** you are a foreign institution that is **not** a foreign graduate medical school, foreign veterinary school, or foreign nursing school **and go to Section J.**
- Check here if you are a foreign graduate medical school, foreign veterinary school or foreign nursing school that is seeking to apply for Title IV, HEA program eligibility for an educational program that prepares students to practice osteopathic or allopathic medicine, veterinary medicine, or nursing, **and** check each program that you wish to be considered for Title IV, HEA program eligibility:
- Osteopathic or Allopathic Medicine
 - Veterinary Medicine
 - Nursing

Section I. - Subsection for Foreign Graduate Medical Schools

47. Identify all locations where your medical students receive basic science or clinical instruction (Note: you are not required to report clinical locations that meet each of the following criteria: they are not used to provide a core or required clinical training rotation, they are not used regularly, but instead are chosen by individual students who take no more than two electives at the clinical training location for no more than a total of eight weeks)

Name of Location/Facility

Address

City, State/Province

Country, Zip Code/Postal Code

Telephone number (Complete international telephone number)

 ext:

Fax number (including area code)

 ext:

E-mail address (if applicable)

Name of contact person at the facility:

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

Identify each type of medical instruction offered at this location.

- Basic Science
- Clinical Instruction
 - Core Clinical
 - Required Clinical
 - Not Required Clinical

48. What entity in your country is legally authorized to evaluate the quality of your graduate medical educational program?

Name of entity

Address

City

Country

Telephone number (Complete international telephone number)

 ext:

Fax number (including area code)

 ext:

E-mail address (if applicable)

Name of contact person at the entity:

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

49. Are you approved by the entity (or entities) listed in Question 48 to provide a graduate medical educational program in your country?

Yes

No

You must include a copy of each approval and its certified English translation.

50. What is the length of the program of graduate clinical and medical instruction?

Months of Instruction

- c. What medical licensing boards and evaluating bodies in the United States currently approve the clinical training in the United States?

--

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- Check here if your institution has continuously, since January 1, 1992, offered a clinical training program in the U.S. with approval from at least one U.S. State. Provide documentation from the State agency or agencies that demonstrate continuous State approval for one or more of your clinical training programs for this timeframe with the supporting documents for this application. List in question XX the U.S. clinical training program facility (or the combination of U.S. clinical training program facilities) that demonstrates your institution has maintained continuous approval to offer a clinical training program by at least one U.S. State since January 1, 1992.
- Check here if your institution has continuously, since January 1, 2008, offered a clinical training program in the U.S. with approval from at least one U.S. State. Provide documentation from the State agency or agencies that demonstrates continuous State approval for one or more of your clinical training programs for this timeframe with the supporting documents for this application. List in question XX the U.S. clinical training program facility (or the combination of U.S. clinical training program facilities) that demonstrates that your institution has maintained continuous approval to offer a clinical training program by at least one U.S. State since January 1, 2008.

Does your foreign graduate medical school provide any of the following types of medical educational programs (check each type of program that is offered):

- Post baccalaureate/equivalent medical programs
- Other types of programs that lead to employment as a doctor of osteopathic medicine, or doctor of medicine

If your institution offers a post-baccalaureate/equivalent medical program, read and answer each of the applicable statements below:

- check here if you require U.S. citizens, U.S. nationals and U.S. lawful permanent residents accepted for admission post-baccalaureate/equivalent medical program to take the Medical College Admission Test (MCAT)
- check here if you require U.S. citizens, U.S. nationals and U.S. lawful permanent residents to report their MCAT scores to you.
- check here if you can report the MCAT scores achieved by U.S. citizens, U.S. nationals and U.S. lawful permanent residents and a statement of the number of times each U.S. citizen, U.S. national or U.S. lawful permanent resident took the MCAT examination.

Review the following statements concerning data collection and reporting, and check

each that apply to your institution:

- Check here if your institution has determined the consent requirements for and requires the necessary consents of **ALL** students accepted for admission for whom the institution must report to comply with data collection and submission requirements, including, but not limited to:

(Check each that applies)

- MCAT scores
- USMLE scores
- U.S. medical residency programs placement rate data
- U.S. citizenship/residency rate data
- Check here if your institution has a data collection and reporting system that allows you to report all required information to the Department of Education and your medical school accrediting agency.
- Check here if a privacy law or a data protection law in your country prevents you from providing MCAT scores, USMLE scores, placement rates in U.S. medical residency programs, or citizenship/residency data for your medical students or graduates to the U.S. Department of Education or to your medical school's accrediting agency.

Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

52. List the dates of graduation and the number of regular students who graduated within the past three 12-month periods.

Dates

Dates

Dates

Graduates

Graduates

Graduates

Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Identify the number of medical school graduates in your most recent medical school graduating class who were U.S. citizens, U.S. Nationals, or eligible noncitizens.

[]

Identify the number of graduates in your most recent medical school graduating class who were not U.S. citizens, U.S. Nationals, or eligible noncitizens.

[]

53. What are the beginning and ending dates of your institution's most recently completed academic year?

Beginning date

Ending date

54. How many full-time regular students were enrolled in your medical school during the most recently completed academic year?

55. How many of the regular students in Question 54 were not persons who met the U.S. citizenship or residency criteria to be eligible for U.S. federal financial aid programs? (Note: To be eligible to receive assistance through the U.S. federal financial aid programs, a student must be a U.S. Citizen, a U.S. National, or an eligible non-citizen. See the Glossary for a definition of “eligible non-citizen.”)

What is the most recently completed calendar year for which USMLE performance data are available? []

Report for each USMLE step/test listed below the number of your medical students or recent graduates who took each step/test as a first-time test-taker during the most recently completed calendar year for which performance data are available. (Note: Recent graduates include each student who graduated from the medical school during the three years preceding the year for which the calculation is performed.)

Step 1	Number of First-time test-takers on this step/test []
Step 2-CS	Number of First-time test-takers on this step/test []
Step 2-CK	Number of First-time test-takers on this step/test []

Identify the method that your institution uses to report USMLE scores to the Department of Education.

- [] Check here if your institution has a Performance Information Agreement (PIA) with the Educational Commission for Foreign Medical Graduates (ECFMG) or other designated third party **AND** you wish the Department to rely on data provided by this entity about the performance your medical students and recent graduates as a first-time test-takers on the following step/tests of the United States Medical Licensing Examination (USMLE): Step 1, Step 2-Clinical Skills (Step 2-CS), and Step 2-Clinical Knowledge (Step 2-CK).

(Note: You must have at least 8 first time test takers in each step/test during the calendar year **AND** you must provide by April 30 written consent that verifies that the pass rate as calculated by ECFMG or other designated third party is reliable and conclusive for purposes of determining compliance. Recent graduates include each student who graduated from the medical school during the three years preceding the calendar year for which the calculation is performed.)

- [] Check here if your institution does not agree to allow the ECFMG or other responsible third party to calculate and provide your institution’s USMLE pass rate data directly to the Secretary of Education **AND** report below USMLE performance data for every

student and every graduate of your medical school who took USMLE Step 1, Step 2-CS, or Step 2-CK during the most recently completed calendar year.

(Note: Do not report personally identifiable information for individual test takers. Reference individual students by a student reference number and retain a cross-reference table in your institution's records.)

- Check here if you reported fewer than 8 first-time test-takers in all of the following USMLE step/test categories: Step 1, Step 2-CS, Step 2-CK **AND** report below the USMLE performance data for every student and every graduate of your medical school who took USMLE Step 1, Step 2-CS, or Step 2-CK during the most recently completed calendar year.

(Note: Do not report personally identifiable information for individual test takers. Reference individual students by a student reference number and retain a cross-reference table in your institution's records.)

SAMPLE DATA Entry Table

Student Reference Number	Test Date (MM/DD/YYYY)	Step/Test attempted	Score	Pass/Fail indicator	Number of Step/Test attempts 1 = 1st-timetaker 2 or more = Repeat	Student/Graduate indicator	Grad Date
2009-1	1/1/2009	Step 1	{value}	Pass	1	Student	
2009-1	3/1/2009	Step 2-CS	{value}	Fail	1	Student	
2009-1	4/15/2009	Step 2-CS	{value}	Pass	2	Student	
2009-2	1/15/2009	Step 2-CS	{value}	Fail	2	Graduate	6/11/2007
2009-2	3/15/2009	Step 2-CS	{value}	Fail	3	Graduate	6/11/2007
2009-2	7/15/2009	Step 2-CS	{value}	Fail	4	Graduate	6/11/2007
2009-2	9/15/2009	Step 2-CS	{value}	Pass	5	Graduate	6/11/2007
2009-3	1/31/2009	Step 2-CS	{value}	Pass	1	Graduate	6/15/2005
2009-3	3/15/2009	Step 2-CK	{value}	Pass	1	Graduate	6/15/2005

- Check here if you need space to continue your answer on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.
- Check here if your medical school is located in Canada and you have an agreement National Board of Medical Examiners (NBME) or other entity to receive test performance data for your medical students and recent graduates who were a first-time test-takers on the following step/tests of the United States Medical Licensing Examination (USMLE): Step 1, Step 2-Clinical Skills (Step 2-CS), and Step 2-Clinical Knowledge (Step 2-CK).
- Check here if your medical school includes as a quantitative component of your institution's satisfactory academic progress standards a maximum timeframe in which

a student must complete his or her educational program within 150 percent of the published length of the educational program measured in academic years, terms, credit hours attempted, clock hours completed, etc., as appropriate.

- Check here if your medical school documents the educational remediation it provides to assist students in making satisfactory academic progress.
- Check here if your medical school clearly publishes all of the languages in which instruction is offered.

Section I. - Subsection for Foreign Veterinary Schools

47. Identify all locations where your veterinary students receive basic science or clinical instruction (Note: if you are a foreign public or foreign private non-profit institution, you are not required to report clinical locations that are not used regularly, but instead are chosen by individual students who take no more than two electives at the clinical training location for no more than a total of eight weeks)

Name of Location/Facility

Address

City, State/Province

Country, Zip Code/Postal Code

Telephone number (Complete international telephone number)

 ext:

Fax number (including area code)

 ext:

E-mail address (if applicable)

accrediting agency where it is located on or before January 1, 1992.
Report the date that your institution ceased to be approved below.

Veterinary accrediting agency approval End Date []

Telephone number (including area code) & ext.

Ext.

Fax Number (including area code) & ext

Ext.

E-mail address (if applicable)

Section I. - Subsection for Foreign Nursing Schools

Does your foreign nursing school meet one or more of the following definitions?
Check each that applies: (definition of a foreign nursing school 34 C.F.R. 600.57) :

- Associate Degree School of Nursing
- Collegiate School of Nursing
- Diploma School of Nursing

Note: See definitions in the glossary

- Check here if your foreign nursing school currently has an agreement with a hospital located in the United States or an accredited school of nursing (as those terms are defined in section 801 of the Public Health Service Act (42 United States Code 296) located in the United States where your nursing students complete clinical training.

Identify below the method(s) by which your institution will obtain the results of the National Council Licensure Examination for Registered Nurses (NCLEX-RN) to report to the Secretary of Education

- Check here if your foreign nursing school has developed a system and entered into agreements to obtain at its own expense all results from students and graduates who are U.S. citizens, nationals or eligible permanent residents on the National Council Licensure Examination for Registered Nurses (NCLEX-RN), together with the dates the students have taken the examination, including failed examinations, in order to provide the results to the Secretary of Education
- Check here if your foreign nursing school has developed a system and entered into an agreement to obtain a report(s) from the National Council of State Boards of Nursing (NCSB), or an NCSB affiliate or NCSB contractor, reflecting the percentage (or data to calculate the percentages) of the school's students and graduates taking the NCLEX-RN in the preceding year who passed the examination in order to provide the results to the U.S. Department of Education.
- Check here if your institution has consent requirements and requires these consents of **ALL** students accepted for admission for whom the institution must collect and report the examination results (e.g. NCLEX-RN)

- Check here if a privacy law or a data protection law in your country prevents you from providing NCLEX-RN results or other data to the U.S. Department of Education or to your medical school's accrediting agency.

What is the most recent calendar year for which NCLEX-RN performance data are available?

Report the NCLEX-RN results for the most recently available year below:

(Note: Do not report personally identifiable information for individual test takers. Reference individual students by a student reference number and retain a cross-reference table in your institution's records.)

SAMPLE DATA reporting table

Student Reference Number	Test Date (MM/DD/YYYY)	NCLEX-RN step? (if appropriate)	Score	Pass/Fail indicator	Number of Step/Test attempts 1 = 1st-timetaker 2 or more = Repeat	Student/Graduate indicator	Grad Date
2009-1	1/1/2009	Step 1	{value}	Pass	1	Student	
2009-1	3/1/2009	Step 2-CS	{value}	Fail	1	Student	
2009-1	4/15/2009	Step 2-CS	{value}	Pass	2	Student	
2009-2	1/15/2009	Step 2-CS	{value}	Fail	2	Graduate	6/11/2007
2009-2	3/15/2009	Step 2-CS	{value}	Fail	3	Graduate	6/11/2007
2009-2	7/15/2009	Step 2-CS	{value}	Fail	4	Graduate	6/11/2007
2009-2	9/15/2009	Step 2-CS	{value}	Pass	5	Graduate	6/11/2007
2009-3	1/31/2009	Step 2-CS	{value}	Pass	1	Graduate	6/15/2005
2009-3	3/15/2009	Step 2-CK	{value}	Pass	1	Graduate	6/15/2005

- Check here if you need space to continue your answer on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

- Check here if your foreign nursing school has graduated classes during each of the two twelve month periods immediately preceding the date of this application and identify those graduation dates and number of nursing school graduates in each graduating class below.

Graduation Date Number of Nursing Graduates

Graduation Date Number of Nursing Graduates

- Check here if your foreign nursing school agrees to reimburse the Secretary of Education for the costs of defaulted student loans for students attending your foreign nursing program.

47. Identify all locations where your nursing students receive basic science or clinical instruction

Name of school/facility

Address

City, State/Province

Country, Zip Code/Postal Code

Telephone number (Complete international telephone number)

 ext:

Fax number (including area code)

 ext:

E-mail address (if applicable)

Name of contact person at the facility:

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

Identify each type of nursing instruction offered at this location.

- Basic Science
- Clinical Instruction

Is this facility a U.S. hospital or an accredited school of nursing? (check all that apply)

- U.S. hospital
- Accredited school of nursing in the U.S.
- other facility

- Check here if this is a location where your student completes nursing clinical training
- Check here if your foreign nursing school has an agreement with this facility to ensure proper oversight of the nursing program.
- Check here if faculty members of the foreign nursing school are based at this facility to ensure proper educational oversight.

- Check here if the facility providing the clinical training program is approved by all licensing boards and evaluating bodies in the jurisdiction where the facility is located. Identify below the licensing boards and evaluating bodies which have approved the clinical training program, and the dates of their approval.

Licensing Board or Evaluating Body []
Approval Start Date [] Approval End Date []

Licensing Board or Evaluating Body []
Approval Start Date [] Approval End Date []

Licensing Board or Evaluating Body []
Approval Start Date [] Approval End Date []

- Check here if students attending your nursing school are eligible to receive a degree in nursing from the U.S. accredited school of nursing listed above

- Check here if you need space to report more than foreign nursing school location and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Section J. Please tell us about your third-party servicers. (This includes your Ability to Benefit Test.)

58. If you contract with any third-party servicer to perform any function relating to federal student financial aid programs, or use an ability to benefit test for students who do not have a high school diploma or its recognized equivalent, provide the following information about each servicer/tester. Identify which ability to benefit test you use.

Note: Do not list independent auditors. Also do not list vendors that provide books, forms, or computer programs (in other words, do not list vendors unless they actually perform services or functions for which you are responsible under the HEA programs).

Name of servicer's contact person
First name, Middle initial, Last name
(include prefix, such as Mr., Ms., Dr.)

Job title

Company name

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

 ext:

Fax number (including area code)

 ext:

E-mail address (if applicable)

Indicate the service provided:

- Performing needs analysis
- Authorizing financial aid
- Disbursing financial aid
- Performing loan servicing
- Counseling/providing information for students
- Performing loan collection
- Preparing/maintaining student aid transcripts
- Other (specify)

- Check here if you need space to give more than one answer and continue on a separate sheet. On the separate sheet, repeat the question being answered, numbering each sheet as page 1 of 3, page 2 of 3, and so on as appropriate for each question. Insert continuation sheets following the page where the question is asked.

Section K. Please assure us of your administrative capability and your financial responsibility.

Note: To expand on any of your answers, use Question 69, or explain why the question was not answered.

59. Do you have a system of internal checks and balances for administering federal student financial aid that meets federal regulations? (See 34 CFR 668.16.)
 Yes
60. Do you divide the functions of determining student awards and disbursing funds that result from those award decisions? (See 34 CFR 668.16.)
 Yes
61. Do you have procedures that ensure frequent, periodic reconciliation of fiscal office and financial aid office award data? (See 34 CFR 668.14, 668.16, 668.24, 674.19, 675.19, 676.19, and 690.81.)
 Yes
62. Do you have a system to identify and resolve discrepancies in information you receive from various sources about a student's application for financial aid? (See 34 CFR 668.16.)
 Yes
63. Do you have a policy that meets federal regulations for requiring satisfactory academic progress for recipients of federal student financial aid? (See 34 CFR 668.16 and 668.34.)
 Yes
64. Do you have procedures that ensure that your requests for federal cash do not exceed the amount of funds you need immediately to make aid disbursements to students? (See 34 CFR 668.163.)
 Yes
65. Do you have a policy that meets federal regulations for returning Title IV funds when a student withdraws from classes? (See 34 CFR 668.22.)
 Yes
- 66a. Have you submitted your required annual financial statement audits to us on time? (For initial applicants, have you established a process to ensure that you submit your required annual financial statement audit to us on time?) (See 34 CFR 668.23.)
 Yes

70 a. (Optional) Provide the following information for any person or firm outside your institution that you wish to designate as your agent to represent you in matters related to this application.

First name, Middle initial, Last name

(include prefix, such as Mr., Ms., Dr.)

Job Title

Company name

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

70 b. Who is your institution's destination point administrator (DPA)?

First name, Middle initial, Last name - No Longer Available

(include prefix, such as Mr., Ms., Dr.)

Job Title

Company Name

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

<input type="text"/>	ext:	<input type="text"/>
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Fax number (including area code)

<input type="text"/>	ext:	<input type="text"/>
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E-mail address (if applicable)

71. Identify gifts received from or contracts entered into with foreign sources that exceed \$250,000 in the calendar year or it is owned or controlled by a foreign source. (Provide conditions or restrictions in Question 69.)

Gift Type

Date received

<input type="text"/>	(mm/dd/yyyy format)
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Amount

Giver Name

Country

Contract Start Date

<input type="text"/>	(mm/dd/yyyy format)
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Contract End Date

<input type="text"/>	(mm/dd/yyyy format)
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Section L. Please have the appropriate person in authority review, sign, and date this document.

I hereby certify that, to the best of my knowledge and belief, all information in this document is true and correct. I understand that if my institution provides false or misleading information, (a) the U.S. Department of Education may deny the institution's request for eligibility to participate in federal student financial aid programs and/or revoke eligibility once it has been granted and (b) the institution may be liable for all federal student financial aid funds it or its students received. I also understand that I may be subject to a fine of not more than \$25,000 or imprisonment of not more than five years, or both, for misinformation that is material to receipt and stewardship of federal student financial aid funds.

Signature of President/CEO/Chancellor

Date

Name of institution

Name of President/CEO/Chancellor

Check here if this is the same person as in Question 10. If not, complete the information below.

Job title

Business street address

City

State (or province) and zip+4 (and country, if outside the U.S.)

Telephone number (including area code)

ext:

Fax number (including area code)

ext:

E-mail address (if applicable)

Section M. Please include copies of appropriate documents as part of your application.

Indicate all copies of documents you are including with this application.

- Current letter of accreditation and any attachments. (See Question 15) (Please Note: The accreditation certificate is not sufficient documentation)
- Valid state license or other state authorization (See Question 17)
- For private nonprofit institutions-501(c)(3) designation from the IRS (See Question 18)
- If your institution contracts with an organization or ineligible institution to provide more than 25% of any educational program-a copy of the approval from your accrediting agency for contracting this program (See Question 28)

For initial applicants (See Question 35)

- Audited financial statements for the (two) most recently completed fiscal year(s)

Default management plan: Either

- The default management plan recommended by the Secretary of Education. (check this box, do not include the plan); *or*
- A default management plan other than the plan recommended by the Secretary of Education. (check this box, do not include the plan); *or*
- The institution is exempt under 487(a)(14)(C) of the HEA from providing a default management plan.

For institutions with a change in ownership or structure (See Question 35)

- Audited financial statements of the institution's two most recently completed fiscal years that are prepared in accordance with Generally Accepted Accounting Principles (GAAP) and audited in accordance with Generally Accepted Government Auditing Standards (GAGAS); and
- Audited financial statements of the institution's new owner's two most recently completed fiscal years that are prepared in accordance with Generally Accepted Accounting Principles (GAAP) and audited in accordance with Generally Accepted Government Auditing Standards (GAGAS) or equivalent information for that owner that is acceptable to the Secretary.
- Same-day balance sheet, audited in accordance with GAGAS, showing the financial condition of the institution after the change in ownership.

Default management plan: Either

- The default management plan recommended by the Secretary of Education. (check this box, do not include the plan); *or*
- A default management plan other than the plan recommended by the Secretary of Education. (enclose a copy of the plan); *or*
- The institution is exempt under 487(a)(14)(C) of the HEA from providing a default management plan.

For institutions seeking reinstatement (See Question 35)

- Audited financial statements for the two most recently completed fiscal years that are prepared in accordance with Generally Accepted Accounting Principles (GAAP) and audited in accordance with Generally Accepted Government Auditing Standards (GAGAS).

Default management plan: Either

- The default management plan recommended by the Secretary of Education. (check this box, do not include the plan); *or*
- A default management plan other than recommended by the Secretary of Education. (enclose a copy of the plan); *or*
- The institution is exempt under 487(a)(14)(C) of the HEA from providing a default management plan.

For foreign institutions, including foreign graduate medical schools

- For private nonprofit institutions-a certified English translation of nonprofit designation status (See Question 18)
- Most recent catalog and its certified English translation of all sections dealing with degrees and programs provided at your institution (See Section I)
- Legal authorization and its certified English translation to provide an educational program beyond the secondary school level in the country where you are located (See Question 42)
- Legal authorization and its certified English translation to award a degree that is equivalent to a degree awarded in the United States (See Question 43)
- Legal authorization and its certified English translation to provide graduate medical education (See Question 49)
- In addition, if a foreign institution is an initial applicant*

- Audited financial statements for the two most recent years

Default management plan: Either

- The default management plan recommended by the Secretary of Education. (check this box, do not include the plan); *or*
- A default management plan other than the plan recommended by the Secretary of Education. (enclose a copy of the plan); *or*
- The institution is exempt under 487(a)(14)(C) of the HEA from providing a default management plan.

For institutions applying for Comprehensive Transition and Postsecondary Programs(See Question 26k)

- A detailed description of your comprehensive transition and postsecondary program addressing all of the components of the program as defined in 34 C.F.R 668.231
- A copy of your institution's Satisfactory Academic Progress policy for the comprehensive transition and postsecondary program
- A copy of the notification to your primary accreditor that your institution is providing a comprehensive transition and postsecondary program

Paperwork Reduction Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1845-0012. The time required to complete this information collection is estimated to average 17 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. **If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to:** U.S. Department of Education, 830 First Street, NE, Washington, DC 20002-5402. **If you have comments or concerns regarding the status of your individual submission of this form, write directly to:** School Participation Management Division, U.S. Department of Education, 830 First Street, NE, Washington, DC 20002-5402.