# Clinical Relocation Expenses Form

Full Name: \_\_\_\_\_\_\_\_\_

Current Residence (City, State): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently reside where or near your clinical site is located?

[ ] Yes [ ] No

* If no, please provide location of clinical site (City, State):

Do you expect to incur additional expenses due to travel?

[ ] Yes [ ] No

* If Yes, please provide estimate and rationale:

|  |  |
| --- | --- |
| **Rationale** | **Estimate ($)** |
|  |  |

Do you expect to incur additional expenses due to housing?

[ ] Yes [ ] No

* If yes, please provide estimate and rationale:

|  |  |
| --- | --- |
| **Rationale** | **Estimate ($)** |
|  |  |

*This information is used solely for Physician Assistant scholarship opportunities. To have your additional clinical expenses considered for federal and private loan funding, please contact* [*One Stop Student Services*](https://und.edu/one-stop/index.html)*.*