**Physician Loan Repayment Program**

**APPLICATION**

**Note:** There is *no deadline* to apply. However, the number of awards is dependent on the number of eligible applications and availability of funding.

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| **APPLICANT INFORMATION** |  |
| Full Name | Date of Birth |
| Gender | Social Security # |
| Ethnicity | Country of Origin |
| Personal Phone | Work Phone |
| Personal Email  | Work Email |
| **EDUCATION** |
| **Type of Medical Degree*** Doctor of Medicine (MD, Dr.MuD, Dr.Med)
* Doctor of Osteopathic Medicine (DO)
* Other(please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | **California Physician License Number** |
| **Name of school(s) from which you received your medical degree(s)**  |
| Name | City/State  | Graduation Date |
| Name | City/State  | Graduation Date |
| Name | City/State  | Graduation Date |
| Are you actively Board Certified in one of the following areas (check all that apply)?* Internal Medicine
* Family Medicine
* Obstetrics & Gynecology
* Pediatrics
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| Are you fluent in a language or languages other than English?* Yes - please indicate language(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No
 |
| Do you speak medical Spanish?* Yes
* No
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| **EMPLOYMENT INFORMATION** |
| Name |
| Corporate/Headquarter Address | Suite/Floor |
| City | State | Zip Code |
| Phone | Fax | Email |
| Date of Hire | Annual Salary |
| Is your employer a contracted provider in L.A. Care’s Medi-Cal network? * Yes
* No
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| **EMPLOYER REPRESENTATIVE** who can verify your hire date and the number of hours of direct patient primary care that you provide weekly at your practice site(s). **Note*:***The Program Administrator may contact your employer at any time during the review and award process to verify application information and employment status updates. |
| Name | Title |
| Address (including suite/floor) |
| City  | State | Zip Code |
| Work Email | Work Phone (include direct extension) |
| **PRACTICE SITE INFORMATION**  |
| Are you committed to serving in L.A. Care’s Medi-Cal Network for at least three years?* Yes
* No
 |
| Will you be providing direct patient care at more than one practice site? * No – please complete details in section *Practice Site #1 only*
* Yes – please provide the following information for individual practice sites below

**IMPORTANT NOTE:** Each suite/floor is considered a practice site |
| **Practice Site #1**  |
| Employer Name | Number of **hours of direct patient primary care** that you provide each week at this site |
| Site Address | Suite/Floor  |
| City  | State | Zip Code |
| Site Phone Number | Site NPI Number  |
| **Practice Site #2**  |
| Employer Name | Number of **hours of direct patient primary care** that you provide each week at this site |
| Site Address | Suite/Floor  |
| City  | State | Zip Code |
| Site Phone Number | Site NPI Number |
| **Practice Site #3**  |
| Employer Name | Number of **hours of direct patient primary care** that you provide each week at this site |
| Site Address | Suite/Floor  |
| City  | State | Zip Code |
| Site Phone Number | Site NPI Number |
| **Practice Site #4**  |
| Employer Name | Number of **hours of direct patient primary care** that you provide each week at this site |
| Site Address | Suite/Floor  |
| City  | State | Zip Code |
| Site Phone Number | Site NPI Number |
| **EDUCATIONAL DEBT INFORMATION** |
| **IMPORTANT NOTE:** For each loan listed, provide copies of the underlying loan documents and promissory notes.Print your name at the top of any additional sheets |
| **Loan 1** | Lender Name | Account Number |
| Phone Number | Original Loan Amount | Current Loan Amount |
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| **Loan 2** | Lender Name | Account Number |
| Phone Number | Original Loan Amount | Current Loan Amount |
|  |
| **Loan 3** | Lender Name | Account Number |
| Phone Number | Original Loan Amount | Current Loan Amount |
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| **Loan 4** | Lender Name | Account Number |
| Phone Number | Original Loan Amount | Current Loan Amount |
| **OTHER LOAN REPAYMENT ASSISTANCE PROGRAM(S):** Eligibility and Participation |
| Are you eligible and participating in other loan repayment assistance programs?* No – there is no other loan repayment program to which I can apply
* Yes – please provide the information for each program in the section below
 |
| **Loan Repayment Program #1** |
| Name of Program  | Type of Program (school-based, employer, state, other) |
| Name of Program Contact  | Title |
| Phone Number  | Email |
| * **APPLIED** - I expect to receive notification by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YEAR or closest approximation).
* **INTEND TO APPLY** – The application deadline is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YEAR).
* **APPLIED and DEEMED ELIGIBLE**. *Please attach a copy of award letter or promissory note from this program*

 Award Amount: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Frequency of Award Distribution (One-time, Monthly, Annually, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Loan Repayment Program #2** |
| Name of Program | Type of Program (school-based, employer, state, other) |
| Name of Program Contact | Title |
| Phone Number  | Email |
| * **APPLIED** - I expect to receive notification by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YEAR or closest approximation).
* **INTEND TO APPLY** – The application deadline is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YEAR).
* **APPLIED and DEEMED ELIGIBLE**. *Please attach a copy of award letter or promissory note from this program*

 Award Amount: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Frequency of Award Distribution (One-time, Monthly, Annually, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Loan Repayment Program #3**  |
| Name of Program  | Type of Program (school-based, employer, state, other) |
| Name of Program Contact | Title |
| Phone Number  | Email |
| * **APPLIED** - I expect to receive notification by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YEAR or closest approximation).
* **INTEND TO APPLY** – The application deadline is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MM/DD/YEAR).
* **APPLIED and DEEMED ELIGIBLE**. *Please attach a copy of award letter or promissory note from this program*

 Award Amount: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Frequency of Award Distribution (One-time, Monthly, Annually, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *Attach additional sheets if necessary. Print your name at the top of any additional sheets.* |

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| **APPLICANT PERSONAL STATEMENT** *(You may use additional pages if necessary)* |
| Please describe how you have demonstrated cultural sensitivity to your patient communities, a long-term interest in providing access to quality health care for vulnerable and low-income individuals and families, and leadership potential in the community health field.  |

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| **REQUIRED DOCUMENTS**  |
| * Completed Application
* Board Certifications
* Most recently filed tax return
* Proof of outstanding educational loan balances (i.e. loan statements)
* Other loan repayment assistance program award letter(s) or promissory note(s), if applicable
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| **SUBMISSION PROCESS:** Submit all materials via mail or e-mail to Program Administrator |
| **MAIL**Uncommon Good211 W. Foothill Blvd.Claremont, CA 91711*Attention*: Nancy Mintie | **EMAIL**nmintie@uncommongood.orgSubject Line: Applicant’s Name,Physician Loan Repayment Program*Attention:* Nancy Mintie |
| **APPLICANT SIGNATURE DISCLAIMER**  |
| I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application may result in my application being dismissed. *Print and Sign Completed Application.**If submitting electronically, please scan and submit as PDF.*Applicant Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Completion Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Program Administrator**

For support, please contact Nancy Mintie, Executive Director, Uncommon Good

 Phone:(909)625-2248 or Email: nmintie@uncommongood.org

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