**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 | | | | | | | | | | | | | |
| Are you fluent in a language or languages other than English?   * Yes - please indicate language(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * No | | | | | | | | | | | | | |
| Do you speak medical Spanish?   * Yes * No | | | | | | | | | | | | | |
| **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 | | | | | | | | | | | | | |
| **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 | | | |
|  | | | | | | | | | | | | | |
| **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 | | | |
|  | | | | | | | | | | | | | |
| **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 Good  211 W. Foothill Blvd.  Claremont, CA 91711  *Attention*: Nancy Mintie | **EMAIL**  [nmintie@uncommongood.org](mailto:nmintie@uncommongood.org)  Subject 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](mailto:nmintie@uncommongood.org)

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