

California's Office of Statewide Health Planning and Development  
California State Loan Repayment Program\*  
Primary Care Health Professional Request for Extension Applicants Only

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Complete each part of the application form. Make sure all supporting documents are submitted with your application. Applications are currently being accepted beginning August 1, 2011 on an ongoing basis until funds are expended. Awards will be made on a first-come, first-served basis.

**PART A: PERSONAL INFORMATION**

Applicant's Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Numbers (provide at least 2): (\_\_\_\_) \_\_\_\_\_ Hm  Wk  Cell

(\_\_\_\_) \_\_\_\_\_ Hm  Wk  Cell

(\_\_\_\_) \_\_\_\_\_ Hm  Wk  Cell

E-mail address (provide at least 1): \_\_\_\_\_ Wk  Personal

\_\_\_\_\_ Wk  Personal

State Loan Repayment Contract Number: \_\_\_\_\_

List languages you speak, read, and or write in addition to English (check all that apply):

1. \_\_\_\_\_ Speak  Read  Write  Basic medical training

2. \_\_\_\_\_ Speak  Read  Write  Basic medical training

3. \_\_\_\_\_ Speak  Read  Write  Basic medical training

**PART B: PERSONAL STATEMENTS**

Attach your personal statements to the application. Your statements must be typed. Restate and number each question along with your answer.

1. Describe for us how the California State Loan Repayment Program has benefited your health career, other than financially.

2. Share a memorable experience you've had working in a health professional shortage area.

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**For Official Use Only:**

Application Rec'd: \_\_\_\_\_ Postmark Date: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

Application: Complete  Incomplete  Ineligible  Applicant cleared by: NHSC  HPEF

Practice Site: On File  Site Type: 330  RHC  FQHC/LAL  CHC  County Clinic

Other: \_\_\_\_\_

MSSA Type: Urban  Rural  Frontier  State Region: Northern  Central  Southern

PC  MH  DC  HPSA ID # \_\_\_\_\_ HPSA Score \_\_\_\_\_ AD

PC  MH  DC  HPSA ID # \_\_\_\_\_ HPSA Score \_\_\_\_\_ AD

Comments:

\*The California State Loan Repayment Program is funded by a grant from the National Health Service Corps.

**PART C: CERTIFICATION OF PRACTICE SITE (to be filled out by the practice site)**

The completed form must bear an original ink signature and be returned with the provider's application. Photocopies and faxed copies are not acceptable. In addition, a supervisor or authorized representative must prepare a letter of recommendation explaining why the provider would be a good candidate for this program.

**PRACTICE SITE INFORMATION**

Please list the actual street address of the practice setting(s) where the applicant is working, or has entered into an agreement to provide services.

\* Practice Site: \_\_\_\_\_ Percentage of time: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ Zip +4: \_\_\_\_\_

Practice Site Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_

\* Practice Site: \_\_\_\_\_ Percentage of time: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ Zip +4: \_\_\_\_\_

Practice Site Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_

**MEMORANDUM OF UNDERSTANDING (MOU) INFORMATION**

Please provide the name of the clinic or parent agency that will enter into a memorandum of understanding with the Office of Statewide Health Planning and Development.

Clinic or Parent Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ Zip +4: \_\_\_\_\_

Contact Person (person who will sign MOU): \_\_\_\_\_

Title: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_

I certify that the practice site or parent agency will pay the applicant prevailing wages and agree not to use the Program's award of educational loan repayments as a means to reduce the recipient's salary or offset those salaries (e.g., deduction of funds from paychecks, etc.). Please indicate below which award amount and number of corresponding years you are committing to if the provider is awarded by checking the appropriate box:

I certify that the practice site and/or parent agency will pay half the award amount not to exceed \$20,000 for year three or year four of full-time committed service (40 hours per week).

I certify that the practice site and/or parent agency will pay half the award amount not to exceed \$7,500 for year three or year four of half-time committed service (20 hours per week).

I certify that the practice site and/or parent agency will pay half the award amount not to exceed \$15,000 for year five of full-time committed service (40 hours per week).

I certify that the practice site and/or parent agency will pay half the award amount not to exceed \$10,000 for year five of half-time committed service (20 hours per week).

Payments will be made (select one):  monthly  quarterly  biannually  annually  other: \_\_\_\_\_

I declare under penalty of perjury that these statements are true and correct.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

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**PART D: EDUCATIONAL DEBT REPORTING**

- List source and amounts of outstanding educational loans used to finance your education. All spaces on this form must be complete even if the information appears on the lender statements that you will be submitting. Any missing information will make the entire application incomplete and it will not be reviewed.
- You must submit evidence of the educational debts listed below. If your loans have been consolidated, submit proof of consolidation.
- Current lender statements need to be dated within 30 days of submission and MUST include the current balance, account number, your name, and the address to which payment is submitted. Online printouts are acceptable as long as they include all of the required information.
- You may only submit proof of debt for those loans obtained during the course of your undergraduate or graduate education which led to your current license/certification as a qualified provider for this program.

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1. Lender Name: \_\_\_\_\_

Lender Address (send payments to): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip +4: \_\_\_\_\_

Account Number: \_\_\_\_\_ Current Loan Balance \$ \_\_\_\_\_

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2. Lender Name: \_\_\_\_\_

Lender Address (send payments to): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip +4: \_\_\_\_\_

Account Number: \_\_\_\_\_ Current Loan Balance \$ \_\_\_\_\_

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3. Lender Name: \_\_\_\_\_

Lender Address (send payments to): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip +4: \_\_\_\_\_

Account Number: \_\_\_\_\_ Current Loan Balance \$ \_\_\_\_\_

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4. Lender Name: \_\_\_\_\_

Lender Address (send payments to): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip +4: \_\_\_\_\_

Account Number: \_\_\_\_\_ Current Loan Balance \$ \_\_\_\_\_

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5. Lender Name: \_\_\_\_\_

Lender Address (send payments to): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip +4: \_\_\_\_\_

Account Number: \_\_\_\_\_ Current Loan Balance \$ \_\_\_\_\_

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**PART E: APPLICATION CERTIFICATION**

I certify that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct and that I am willing to sign, or have signed a written agreement with a practice setting committing to a minimum two years of practice. I authorize representatives of the Office of Statewide Health Planning and Development to contact educational institutions I attended, institutions holding any of the listed educational loans, and employers to verify the accuracy of the information contained in this application.

**Third Year Extension Only**

- I certify that I will commit to a third year of full-time (40 hours per week) service for a total award amount of up to \$40,000.
- I certify that I will commit to a third year of half-time (20 hours per week) service for a total award amount of up to \$15,000. I further acknowledge that I cannot resume full-time status until I complete the current term.

**Fourth Year Extension Only**

- I certify that I will commit to a fourth year of full-time (40 hours per week) service for a total award amount of up to \$40,000.
- I certify that I will commit to a fourth year of half-time (20 hours per week) service for a total award amount of up to \$15,000. I further acknowledge that I cannot resume full-time status until I complete the current term.

**Fifth Year Extension Only**

- I certify that I will commit to a fifth year of full-time (40 hours per week) service for a total award amount of up to \$30,000.
- I certify that I will commit to a fifth year of half-time (20 hours per week) service for a total award amount of up to \$20,000. I further acknowledge that I cannot resume full-time status until I complete the current term.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Submission Check List:**

- Completed Application
- Personal Statements
- Certification of Practice Site
- Letter of Recommendation from Practice Site
- Educational Debt Reporting Form and Lender Statements

**Submit application and required documents to: OSHPD/HWDD  
State Loan Repayment Program  
400 R Street, Suite 330  
Sacramento, CA 95811**