HEALTH PROFESSIONS
EDUCATION FOUNDATION

STEVEN M. THOMPSON PHYSICIAN CORPS LOAN REPAYMENT PROGRAM (STLRP)
CERTIFICATION OF PRACTICE SETTING - Page 1

Both pages of this form must be completed and uploaded on https://eapp.oshpd.ca.gov/funding/ for your application to be considered complete. This form must be completed and signed by an Administrative Officer or your direct Supervisor employed at the practice site listed below. This form must bear an original ink signature. If you work at more than one site, one Certification of Practice Setting (COPS) must be completed and uploaded for each site.

Applicant Name:_____ **Employer Name:**_____

Average number of hours worked per week at this site:_____ **Number of hours in direct patient care:**_____

Employer Address:_____ **Start Date:**_____

Applicant's Specialty: (Select all that apply)

Family Physician ☐ General Internist ☐ General Pediatrician ☐ General Psychiatrist ☐

Gerontologist ☐ Obstetrician/Gynecologist ☐ Other(s):

The applicant speaks the following Medi-Cal threshold language(s) in the work setting: (Select all that apply)

Arabic ☐ Armenian ☐ Cambodian ☐ Chinese (Mandarin or Cantonese) ☐ Farsi ☐ Hindi ☐

Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Punjabi ☐ Russian ☐ Spanish ☐

Tagalog ☐ Thai ☐ Vietnamese ☐

1. **I have completed the *Practice Site Eligibility Worksheet* on Page 2 of this document and confirm this practice site is eligible for STLRP.** YES ☐ NO ☐
2. **The facility is a geriatric care setting or the applicant works in a setting that primarily serves adults over the age of 65 years or adults with disabilities.** YES ☐ NO ☐

By signing this form below, I certify that the practice site will pay the applicant prevailing wages and I 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.). I am the Supervisor or Administrative Officer at this facility and I declare under penalty of perjury that the statements above are true and correct.

Supervisor or Administrative Officer Name:_____

Title:_____ Phone/Ext:_____X_____

Email:_____

Signature:_____ Date:_____

Don't forget Supervisor or Administrative Officer's original ink signature and date!

Applicants: upload both pages of this form and input the information provided above at https://eapp.oshpd.ca.gov/funding/

NOTE: Pages 1 and 2 of this form MUST be completed fully and submitted by the deadline in order to be eligible. Failure to complete the form completely and or accurately will automatically deem your application ineligible for the STLRP program.

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At least 90% of direct patient care hours must be spent working in an outpatient setting, not a hospital.
Exception: Emergency Room Physicians providing care to patients not admitted to the hospital.

Are you practicing outpatient care: YES ☐ NO ☐

To confirm your practice site is eligible, please follow the instructions below.

STEP 1: In order to be eligible, your practice site must be in a medically undeserved area. To determine if your site is in a medically undeserved area, visit the Program Information page here: https://oshpd.ca.gov/loans-scholarships-grants/loan-repayment/stlrp/

Note: your practice site must be in a Health Professional Shortage Area-Primary Care (HPSA-PC) or Primary Care Shortage Area (PCSA) in California.

OR

Be currently working at a Tribal Health Clinic or Federally Qualified Healthcare Center (FQHC). If your location is a Tribal Health Clinic or FQHC, you may bypass the location eligibility search as your worksite automatically qualifies with a Health Professional Shortage Area (HPSA) designation. Please proceed to confirming your worksite eligibility under wither Section A or B of the COPS form below.

OR

If you work in a Rural Healthcare Center, please contact HPEF staff at 916-326-3640 to confirm your worksite's HPSA designation status. Once your worksite's designation is confirmed, please proceed to confirming eligibility under with Section A or B of the COPS form.

I confirm the practice site is in a medically undeserved area. YES ☐ NO ☐

My practice site is designated as a: HPSA-PC ☐ PCSA ☐ FQHC ☐ Indian Tribal Clinic ☐
Rural Healthcare Center ☐ County Facility ☐ State Facility ☐

STEP 2: Your practice site must be a clinic or physician owned facility that meets the requirements of **either** section A or section B below. Please check the appropriate boxes in either section A or section B to determine if your practice site is eligible for STLRP.

Section A
In order to qualify under section A, the clinic must meet at least one of the criteria in each category below.

Type of Practice Site: (Select One)

☐ A community clinic that is a primary care clinic, operated by a tax-exempt nonprofit organization or an Indian Tribal clinic as defined in subdivision (a) of Section 1204 and subdivision (c) of Section 1206 of the Health and Safety Code.

☐ A clinic owned or operated by a public hospital and health system, or

☐ A clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role pursuant to Section 17000 of the Welfare and Institutions Code.

Patients Served:

☐ At least 50% of the patients seen in this clinic either are Medi-Cal or are uninsured.

Section B
In order to qualify under section B, the clinic must meet the criteria listed in each category below.

Type of Practice Site:

☐ The practice site must be a physician owned and operated medical practice that provides primary care.

Patients Served:

☐ At least 50% of the patients seen in this clinic are either uninsured, insured by Medi-Cal, or are beneficiaries of another publicly funded program that serves patietns who earn less than 250% of the federal poverty level.

STEP 3: I confirm, after completing STEPS 1 and 2 above, the practice site qualified for STLRP. YES ☐ NO ☐