



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

To be completed by applicant

Applicant's Name: _____

This authorization is to release information concerning my employment as required below. To establish eligibility for the Health Professions Education Foundation STLRP Program, verification of employment is required. Please complete this form as soon as possible and return it to HPEF. Your cooperation and prompt return of this information is appreciated.

Signature of Applicant

Date

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) form must be completed and uploaded for each site.

Employer name: _____ Start date: _____

Employer address: _____

Average number of hours worked per week: _____ Number of hours in direct patient care: _____

Applicant's Specialty (**Select all that apply**):
Family Physician General Internist General Pediatrician
General Psychiatrist Gerontologist Obstetrician/Gynecologist Other: _____

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

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 underserved area (MUA). To determine if your site is in a MUA, visit the Program Information page here: <https://oshpd.ca.gov/loans-scholarships-grants/loan-repayment/stlrp/>.

I confirm the practice site is in a medically underserved area: YES NO

My practice site is designated as a:
Health Professional Shortage Area - Primary Care (HPSA-PC) County Facility
Primary Care Shortage Area (PCSA) Federally Qualified Healthcare Center (FQHC) Rural Healthcare Center
Indian Tribal Clinic State Facility

Rev. 1/21/2020

Applicant: Upload this form and input the information provided above <https://eapp.oshpd.ca.gov/funding/>.



**STEVEN M. THOMPSON PHYSICIAN CORPS LOAN REPAYMENT PROGRAM (STLRP)
CERTIFICATION OF PRACTICE SETTING (PART 2)**

To be completed by applicant

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.

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 wither are Medi-Cal or are uninsured.

Section B

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

Type of Practice Site:

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 patients who earn less than 250% of the federal poverty level.

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

To be completed by an Administrative Officer or your Direct Supervisor

1. I understand that, should the applicant be awarded, I agree to sign Progress Reports verifying that this employee is providing direct patient care until the service obligation is complete.
2. I declare under penalty of perjury that the information contained in this section is true and correct to the best of my knowledge.

Direct Supervisor or Administrative Officer Name, Title

Phone

Direct Supervisor or Administrative Officer Signature

Date

Rev. 1/21/2020

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