



# QUARTERLY REPORT # PROGRAM NAME:

# HPEF

## - THIS SECTION IS TO BE FILLED OUT BY THE STUDENT -

**LOAN REPAYMENT RECIPIENTS**, PLEASE ATTACH A CURRENT LENDER STATEMENT OF A LOAN SPECIFIED ON YOUR CONTRACT, WHICH YOU WOULD LIKE US TO PAY THIS QUARTER. ALSO INCLUDE YOUR MOST RECENT PAYCHECK STUB.

**SCHOLARSHIP RECIPIENTS**, PLEASE ATTACH YOUR MOST RECENT PAYCHECK STUB.

**PAYMENT ON YOUR DEBT WILL NOT BE PROCESSED UNTIL THIS INFORMATION IS RECEIVED. FAILURE TO SUBMIT THIS FORM MAY FORCE OUR OFFICE TO CONSIDER YOU IN BREACH OF CONTRACT.**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE INITIAL: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: ( ) \_\_\_\_\_ CONTRACT #: \_\_\_\_\_

HEALTH PROFESSIONAL LICENSE #: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

The purpose of this report is to verify that you are complying with your obligation to practice full-time service (32 hours or more per week) in direct patient care in a medically underserved area or qualified facility of California, as stated in your contract. Falsification of any information required in this form shall be deemed a breach of contract.

WORK SITE: \_\_\_\_\_ NEW EMPLOYER?  YES  NO

SITE ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE NUMBER: ( ) \_\_\_\_\_

DAYS WORKED PER WEEK: \_\_\_\_\_ HOURS WORKED PER DAY: \_\_\_\_\_

Sign below to certify that you have fulfilled the service in direct patient care at the above identified work site for the period of: \_\_\_\_\_ to \_\_\_\_\_.  
(month/year) (month/year)

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## - THIS SECTION IS TO BE FILLED OUT BY YOUR SUPERVISOR -

By signing below, I verify the above information is correct.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Phone Number

