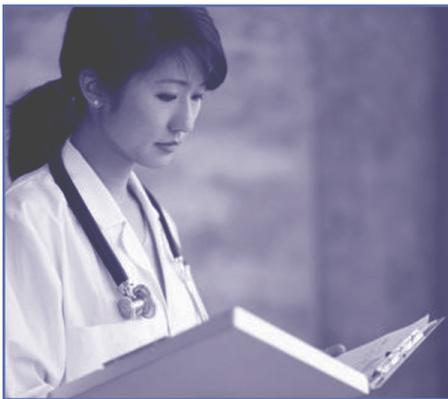


HEALTH PROFESSIONS
EDUCATION FOUNDATION

Giving Golden Opportunities



Physician Corps Loan Repayment Program

Loan Repayment Application

Spring Postmark Deadline: March 24, 2009

*Giving Golden
Opportunities by:*

*Increasing the supply of physicians
practicing in underserved areas*

*Improving access to healthcare in
rural and urban areas of
California*

*Awarding physicians who
are dedicated to practicing in
underserved communities*

Application Instructions



If you want receipt confirmation, please submit one self-addressed stamped envelope with your application.

You must be a California resident and a citizen or permanent resident of the U.S. to apply.

The Health Professions Education Foundation (Foundation) recognizes the necessity of improving conditions which lead to healthcare disparities in the state, including those disparities arising from cultural and linguistic barriers. At the same time, the Foundation acknowledges the difficulty of recruiting physicians who can provide culturally and linguistically appropriate services to the underserved areas because of the heavy debt they accrue while acquiring a medical education. The Physician Corps Loan Repayment Program encourages physicians licensed to practice medicine for the first time in the United States or Canada within the past 15 years to practice in underserved locations in California by authorizing a plan for repayment of their educational loans in exchange for their service in a designated underserved area for a minimum of three (3) years.

The Physician Corps Loan Repayment Program repays up to \$105,000 in outstanding government or commercial educational loans for expenses incurred for undergraduate education and graduate medical education.

Loan repayment recipients will be required to sign a written contract with the Foundation outlining the provisions which must be met in order to fulfill the obligations under this program. Failure to comply with the terms of the contract may result in the awardee's repayment of funds plus interest.

LOAN REPAYMENT AWARDS

The Foundation, under the Physician Corps Loan Repayment Program, is authorized to repay outstanding government and commercial educational loans only, for expenses incurred during undergraduate and graduate medical education (i.e., principal, interest, and related expenses for tuition, educational expenses, and reasonable living cost). Award recipients are responsible for making continued loan payments during the course of their participation in this program, since the program only makes payments at the end of each service year.

A maximum of \$105,000 may be made available to program participants as an educational loan repayment. After completing the first year of service, the participant may receive up to \$25,000; after the second year, up to \$35,000; and, after the third year, up to \$45,000.

In no event shall the cumulative amount of the educational loan repayments exceed the amount of the participant's outstanding educational loan balances as of the date the written agreement is signed between the Foundation and the award recipient.

If the amount awarded is less than \$105,000, then 24 percent of the award will be granted at the end of the first year of service, 33 percent at the end of the second year of service, and 43 percent at the end of the third year of service.

LOAN REPAYMENT ELIGIBILITY

Loan repayment awards are available to physicians who hold a full and unrestricted license to practice medicine in California. Doctors of Osteopathic medicine are not eligible for the program.

If you are not licensed to practice medicine in California when you apply to the loan repayment program, you must ensure that your Physician's and Surgeon's Application is submitted to the California Medical Board promptly. In order to be eligible for participation in the loan repayment program, you must be licensed in California before the final filing date. If you are not licensed by the final filing date, the application shall not be considered and shall be returned to the applicant. Physicians awarded under this program must complete a three (3) year service obligation to practice as a full-time physician in a medically underserved area of California providing direct patient care. Full-time means providing medical services for a minimum of 40 hours per week, for a minimum of 45 weeks per year. The 40-hours per week may be compressed into no less than 4 days per week, with no more than 12 hours of work in any 24-hour period. This does not include hours spent on call. At least 32 hours per week must be spent providing clinical services at the approved practice site(s) during normal office hours, except that, for physicians who are continuously engaged in the practice of obstetrics, at least 21 hours must be spent providing clinical services in addition to deliveries and other inpatient coverage. Absence from the practice cannot exceed 7 weeks in a calendar year except as otherwise required in order to comply with applicable federal and state laws.

SELECTION CRITERIA

The most qualified applicants will be selected in the areas of California with the greatest need: healthcare settings in medically underserved areas with at least 50 percent of the patients from a medically underserved population. Priority consideration will be given to the applicants best suited to meet the cultural and linguistic needs and demands of patients, based on the applicant meeting one or more of the following criteria:

- Speak a Medi-Cal threshold language: Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Mandarin, Other Chinese, Russian, Spanish, Tagalog, or Vietnamese.
- Come from an economically-disadvantaged background.
- Have received significant training in cultural and linguistically appropriate service delivery.
- Have three (3) years of experience working in medically underserved areas or with medically underserved populations.
- Have recently obtained a license to practice medicine in any state of the United States or in Canada.

Priority will be given to those applicants who have completed a three (3)-year postgraduate residency in the areas of family practice, internal medicine, pediatrics, or obstetrics/gynecology; however, up to 20 percent of the available positions may be filled by applicants from other areas. Other criteria will be used in selecting those persons best suited for this program.

Application Instructions (cont.)



ELIGIBLE PRACTICE SETTINGS

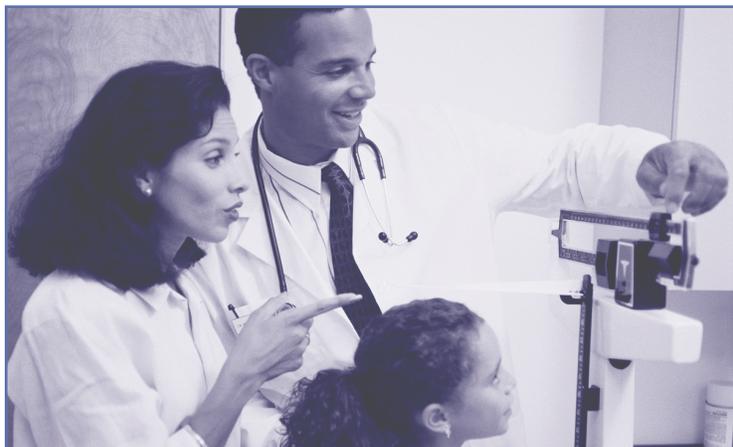
When submitting an application, the applicant may already be working at, or must have entered into a written agreement to provide services under this program with an appropriate practice setting. If an applicant is proposing a work arrangement with multiple practice settings, the applicant shall list those clinics on a separate page and identify the percentage of hours to be provided at each site.

An appropriate practice setting as defined in California Health and Safety Code Section 128552(f) means, in part, either: (1) a community clinic, 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 the California Welfare and Institutions Code, which is located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved population; (2) a medical practice located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved population.

Medically Underserved Areas (MUAs) as defined in California Health and Safety Code Section 128552(d), in part, are areas as defined in the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist under the California Health and Safety Code.

Medically Underserved Population (MUP) as defined in California Health and Safety Code Section 128552(e) are the Medi-Cal, Healthy Families, and uninsured populations.

Clinics must pay prevailing wages to program participants. Clinics must 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.).



SUBMIT THE FOLLOWING

1. Completed Application

Complete all pages of this application. It must be completed, signed, and dated to be considered eligible.

2. Personal Statement

Attach your personal statement to the application. Your statement must be typed and double spaced and no more than one (1) page. Restate and number each question along with your answer.

3. Certification of Practice Setting

Please list the practice setting at which you are working or have entered into a written agreement to provide services under this program during the next three years. If you are proposing a work arrangement with multiple practice settings, please list these clinics on a separate sheet and identify the percentage of hours to be provided at each site. Further, each practice setting's Administrative Office must sign a certification.

4. Educational Debt Reporting Form

Submit the attached educational debt reporting form. If any information is not filled in, the application will be considered ineligible.

5. Lender Statements

Attach copies of your most recent lender statements (no more than six (6) months old) with your name, the name of the lender, balance owed, account number, and monthly payments.

APPLICATION SUBMISSION

Applications must be postmarked by the deadline. In order to be reviewed, each part of the application must be completed. All supporting documentation must be submitted by the appropriate deadline. The Foundation will notify applicants if their application is received incomplete.

Submittal of an application and a written agreement with an acceptable practice setting does NOT ensure that applicants will receive a loan repayment. Awards are contingent upon available funding.

NOTIFICATION OF AWARDS

The Foundation will notify applicants of their application results within 120 days of the final filing date.

For additional information on how to complete this application, please visit the Foundation's website to access Frequently Asked Questions, a technical assistance call center and a powerpoint presentation.

APPLICATION POSTMARK DEADLINE: MARCH 24, 2009

Submit applications to:
Health Professions Education Foundation
Physician Corps Loan Repayment Program
400 R Street, Suite 460
Sacramento, CA 95811
(800) 773-1669 or (916) 326-3640

Application

_____,
Last Name

First Name



Please refer to the application instructions when completing the application. Complete all pages of the application form, and make sure all supporting documents are submitted with your application. All documents must be postmarked by the application deadline. Late or incomplete application packets will not be evaluated.

Please enter the amount you are requesting (up to \$105,000): _____

PART A - PERSONAL INFORMATION

Applicants may apply for only one award using this application (Please type or print your answers legibly in the space provided).

<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last Name:	First Name:	Middle Initial:
CA Drivers License Number:		*Social Security Number:	
Mailing Address:			
City:		State:	Zip Code:
County:			
Permanent Address (if different than above):			
City:		State:	Zip Code:
County:			
Home Phone: ()		Date of Birth:	
Cell Phone: ()		E-mail Address:	
Work Phone: ()			
Are you a citizen or permanent resident of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a California resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently owe an existing service obligation to another entity? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>"Service obligation" means the contractual obligation agreed to by the recipient of a loan repayment where the recipient agrees to practice their profession for a specified period of time in or through a designated facility.</i>			

PERSONAL INFORMATION NOTIFICATION

The Information Practices Act of 1977 and the Federal Privacy Act require this program to provide the following to individuals who are asked by the Office of Statewide Health Planning and Development, Health Professions Education Foundation to supply information: The principal purposes for requesting personal information are for verification of identification, establishment of eligibility and program administration. Program regulations (Chapter 13.2 of Title 16 of the California Code of Regulations, Sections 1313.01 et seq.) require every individual to furnish appropriate information for application to the Steven M. Thompson Physician Corps Loan Repayment Program. All requested information is required unless it is specifically identified as voluntary. Failure to furnish this information may result in the return of the application as incomplete. An individual has a right of access to records containing his/her personal information that are maintained by the Office of Statewide Health Planning and Development, Health Professions Education Foundation. The person responsible for maintaining the information is the Program Director, Health Professions Education Foundation, 400 R Street, Sacramento, Suite 460, CA 95811, (916) 326-3640. The Foundation may charge a mail fee to cover the cost of duplicating this information.

*MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS

Disclosure of your U.S. Social Security Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application will not be processed AND you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

FOR OFFICIAL USE ONLY

Recd:	Compl / Inc:	Omitted: App Pgs	CPS	EDR	LS	Other
Input By:	Elig Prac Set: Yes / No	CT#:				
Reviewed By:	Comments:					

Applicant's Name: _____

PART B – QUALIFICATIONS & ELIGIBILITY

1. Do you hold a full and unrestricted license to practice medicine in California?
 Yes No

If yes, provide license # _____ Date of initial issuance: ____/____/____

2. Are you licensed to practice medicine in any other jurisdiction in the United States or Canada?
 Yes No

If yes, which jurisdiction? _____ Date of initial issuance: ____/____/____

3. Check any Medi-Cal threshold languages that you are fluent in and submit verification.

- | | | |
|------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Hmong | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Armenian | <input type="checkbox"/> Korean | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Other Chinese | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Farsi | | |

4. From which medical school did you graduate? _____
What was the language of instruction? _____

5. Did you complete a medical exchange program during medical school or postgraduate training in which you provided services to a population that speaks a Medi-Cal threshold language?
 Yes No

If yes, where did you serve? _____
Which language was spoken? _____
From: ____/____/____ To: ____/____/____

6. Have you received significant training in cultural and linguistically appropriate service delivery?
 Yes No

7. Do you have at least three (3) years of experience working in any field (whether medically related or not) in MUAs or with MUPs?
 Yes No

8. How many years of experience do you have working in a medically related field in an MUA or serving MUPs? _____

9. Please list any Accreditation Council for Graduate Medical Education (ACGME) or Royal College of Physicians and Surgeons of Canada (RCPSC) postgraduate training programs you have completed or are currently enrolled in.

Facility Name: _____
City: _____ State: _____ Zip Code: _____
Years in program? ____ From: ____/____/____ To: ____/____/____
Specialty: _____ Completed Currently Enrolled

Facility Name: _____
City: _____ State: _____ Zip Code: _____
Years in program? ____ From: ____/____/____ To: ____/____/____
Specialty: _____ Completed Currently Enrolled

10. Have you completed a fellowship?
 Yes No

If yes, in the specialty area of: _____
Facility Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Dates of Attendance: From: ____/____/____ To: ____/____/____

11. Are you certified by a member board of the American Board of Medical Specialties?
 Yes No

If yes, list Board: _____

Date first certified:- ____/____/____

12. Do you come from an economically disadvantage background (i.e. low-income or subsidized income from local, county, state, and/or federal agencies)?
 Yes No

PART C – PERSONAL STATEMENT

Attach your personal statement to the application. Your statement must be typed and double spaced and no more than one (1) page. Restate and number each question along with your answer.

1. Why do you want to participate in the Physician Corps Loan Repayment Program?
2. Please include any other information you feel is relevant.

PART D – QUESTIONNAIRE

1. Where did you hear about the Physician Corps Loan Repayment Program?

(Check all that apply)

- | | | | |
|---|--|--|--------------------------------|
| <input type="checkbox"/> Work (employer or co-worker) | <input type="checkbox"/> Friend/Acquaintance | <input type="checkbox"/> TV | |
| <input type="checkbox"/> Foundation Web site | <input type="checkbox"/> Other Web site | <input type="checkbox"/> Advertisement | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Newspaper or Publication (please specify) _____ | | | |
| <input type="checkbox"/> Organization or Affiliation (please specify) _____ | | | |
| <input type="checkbox"/> Other Source (please specify) _____ | | | |

2. Where did you receive the Physician Corps Loan Repayment Program application form? (Check only one.)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Program Director/Instructor | <input type="checkbox"/> Foundation Office | | |
| <input type="checkbox"/> Foundation Web Site | <input type="checkbox"/> Other Web Site | <input type="checkbox"/> Work (employer/co-worker) | |
| <input type="checkbox"/> Friend/Acquaintance | | | <input type="checkbox"/> Other (please specify) _____ |

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 three years of full-time practice (40 hours per week) in a medically underserved area. I authorize the Foundation to verify any information submitted as part of this application. I understand that falsification of information contained in this application will disqualify my application.

I understand that once submitted my application and supporting documents become the property of the Foundation. I also understand that my personal statement becomes the property of the Foundation and may be used, including but not limited to, advertising/marketing, program reports, newsletters, and other publications.

Last Name: _____

First Name: _____ Middle Initial: _____

Applicant's Signature: _____

Date: _____

SUBMISSION CHECKLIST

- 1. Completed Application
- 2. Personal Statement
- 3. Certification of Practice Setting
- 4. Educational Debt Reporting Form
- 5. Lender Statements

Certification of Practice Setting

Please list the actual street address of the practice setting where the applicant is working, or has entered into an agreement to provide services under this program during the next three (3) years. **This form must be completed by the administrative officer employed at the practice setting listed below.**

Applicant's Name: _____

Practice Setting: _____

Address: _____

City: _____ State: _____ Zip Code: _____

County: _____

Start Date: ____/____/____ F/T or P/T % of hours to be provided at this site: _____

I can verify that the applicant can speak the following Medi-Cal threshold language(s):

- | | | | |
|------------------------------------|---------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Farsi | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Armenian | <input type="checkbox"/> Hmong | <input type="checkbox"/> Other Chinese | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Korean | <input type="checkbox"/> Russian | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Cantonese | | | |

I certify that the practice setting will pay the applicant prevailing wages and that 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 certify that I am the administrative officer at this facility, which meets the definition of a "practice setting" as defined in California Health and Safety Code Section 1285522(f). This information will be verified with the Health Professions Education Foundation.

Name: (Please Print) _____

Signature: _____

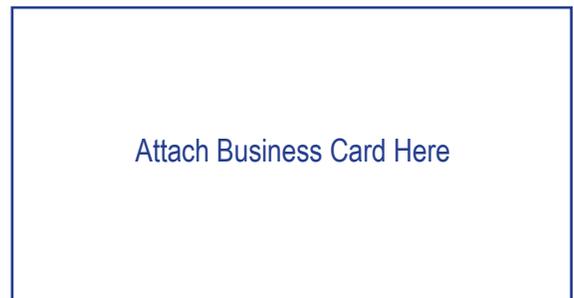
Title: _____

Phone Number: _____

Fax Number: _____

Email: _____

Date: _____



Educational Debt Reporting Form

All spaces must be completed. If any information is missing the application will be considered incomplete. You must submit current lender statements (dated within six (6) months of the application deadline) for the educational debt listed below. They should include your name, the name of the lender, balance owed, account number and monthly payments.

LOAN 1

School Attended: _____

Loan Period (Start Date): _____ (End Date): _____

Loan Program: _____

Loan ID#: _____

Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip Code: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____

LOAN 2

School Attended: _____

Loan Period (Start Date): _____ (End Date): _____

Loan Program: _____

Loan ID#: _____

Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip Code: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____

LOAN 3

School Attended: _____

Loan Period (Start Date): _____ (End Date): _____

Loan Program: _____

Loan ID#: _____

Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip Code: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____

LOAN 4

School Attended: _____

Loan Period (Start Date): _____ (End Date): _____

Loan Program: _____

Loan ID#: _____

Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip Code: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____

LOAN 5

School Attended: _____

Loan Period (Start Date): _____ (End Date): _____

Loan Program: _____

Loan ID#: _____

Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip Code: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____

LOAN 6

School Attended: _____

Loan Period (Start Date): _____ (End Date): _____

Loan Program: _____

Loan ID#: _____

Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip Code: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____



**HEALTH PROFESSIONS
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www.healthprofessions.ca.gov
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