

**Healthcare Workforce Development Division**

400 R Street, Suite 330
Sacramento, California 95811-6213
(916) 326-3700
Fax (916) 322-2588
www.oshpd.ca.gov



California
National Health Service Corps/State Loan Repayment Program
Primary Care Health Professional Application

Instructions for Submitting an Application

- Before submitting an application, please speak with the Human Resources unit or Recruiter at your perspective site to ensure that they are willing to participate in the program with you.
- Applications will only be accepted during the annual application period, August 1 through October 1. Applications postmarked after the deadline (October 1) will not be accepted.
- The current fiscal year application form must be used for submission. The form title includes the current grant period. Please go to www.oshpd.ca.gov/HWDD/SLRP.html to access the most current application.
- The completed application package must include:
 - Personal Statements, Part D of the application;
 - Certification of Practice Site, Part G of the application;
 - A letter of recommendation from the practice site; and
 - Copy of current lender statements (dated within one month of application submission) for each loan to be included in the loan repayment. The lender statement must include the applicant's name and the mailing address of the lender.
- Mail application package to: OSHPD/HWDD
State Loan Repayment Program
400 R Street, Suite 330
Sacramento, CA 95811
- Applications received during the open application period will be ranked according to the evaluation criteria:
 - Training or work experience in a medical, dental or mental health underserved area;
 - Cultural competency training and/or work experience; and
 - Fluency in a second language.
- Other factors that may be relevant in the selection are:
 - Geographic distribution of SLRP awardees;
 - Distribution by discipline (Primary Care Physicians, Dentists, Mental Health Providers, and Mid-level Providers);
 - Area of greatest unmet need; and
 - Rural/Frontier vs. Urban award distribution.
- Notification of award will be sent out within 6 weeks of the end of the application period.
- If you would like to be notified when your application is received, please include a self-addressed stamped post card or envelope with your application.
- If you have questions regarding the application, scoring criteria, or eligibility, please e-mail the program administrator at SLRP@oshpd.ca.gov.

NHSC/State Loan Repayment Program Primary Care Health Professional Application

2009/2010 Grant Period

Please refer to the application instructions before you begin. Complete each part of the application form. Make sure all supporting documents are submitted with your application. Applications must be postmarked by the October 1, 2009 application deadline. Late applications will not be evaluated. Please note that this application is only good for the 2009/2010 grant period.

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

Social Security Number: _____ CA Drivers License/ID: _____

Date of Birth: _____ Gender: Male Female

Race/Ethnicity:

American Indian or Alaska Native	<input type="checkbox"/>	Hispanic or Latino	<input type="checkbox"/>
Asian	<input type="checkbox"/>	Native Hawaiian or Other Pacific Islander	<input type="checkbox"/>
Black or African American	<input type="checkbox"/>	White or Caucasian	<input type="checkbox"/>
Other*	<input type="checkbox"/>		

*Please specify: _____

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: QUALIFICATIONS AND ELIGIBILITY

1. Are you a United States citizen? Yes No

2. Do you have a current and unrestricted California license to practice your profession? Yes No

3. Do you owe an existing service obligation to another entity?
(If yes, please provide explanation in your personal statements, Part D of this application) Yes No

4. Are you free of judgments arising from Federal debt?
(If no, please provide explanation in your personal statements, Part D of this application) Yes No

5. Are you delinquent with any court ordered child support?
(If yes, please provide explanation in your personal statements, Part D of this application) Yes No

PART C: HEALTH PROFESSION INFORMATION

MD <input type="checkbox"/>	DO <input type="checkbox"/>	Physician Assistant <input type="checkbox"/>	Clinical/Counseling Psychologist <input type="checkbox"/>
<i>(Indicate primary specialty)</i>		Nurse Practitioner <input type="checkbox"/>	Licensed Clinical Social Worker <input type="checkbox"/>
Family Physician <input type="checkbox"/>		Certified Nurse-Midwife <input type="checkbox"/>	Mental Health Counselor <input type="checkbox"/>
General Internist <input type="checkbox"/>		Dentist (D.D.S) <input type="checkbox"/>	Licensed Professional Counselor <input type="checkbox"/>
General Pediatrician <input type="checkbox"/>		Dentist (D.M.D) <input type="checkbox"/>	Marriage and Family Therapist <input type="checkbox"/>
Obstetrician-Gynecologist <input type="checkbox"/>		Dental Hygienist <input type="checkbox"/>	Psychiatric Nurse Specialist <input type="checkbox"/>
General Psychiatrist <input type="checkbox"/>			

School: _____ Date of Graduation: _____

City: _____ State: _____ Zip: _____

Postgraduate Training: _____ Year Completed: _____

Board Eligible: Board Certified: California License Number: _____

Certificate Number: _____

PART D: 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 the types of training or work experience you have had in a medical, dental, or mental health professional shortage area.
2. Describe any cultural competency training and/or life experience you may have (include number of units completed in college or CME).
3. Why do you want to participate in the NHSC/State Loan Repayment Program?
4. If applicable, explanations for questions answered in Part B of this application.

Part E: QUESTIONNAIRE (optional)

1. Where did you hear about California's NHSC/State Loan Repayment Program? (check all that apply)

<input type="checkbox"/> Work (employer/co-worker)	<input type="checkbox"/> Family member, Friend, or Acquaintance
<input type="checkbox"/> State Loan Repayment Program Website	<input type="checkbox"/> NHSC Website
<input type="checkbox"/> Other Website (please specify) _____	
<input type="checkbox"/> Organization or Affiliation (please specify) _____	
<input type="checkbox"/> Other Source (please specify) _____	

2. Where did you receive the California NHSC/State Loan Repayment Program application form?

<input type="checkbox"/> Work (employer/co-worker)	<input type="checkbox"/> Family member, Friend, or Acquaintance
<input type="checkbox"/> State Loan Repayment Program Website	<input type="checkbox"/> State Loan Repayment Program Office
<input type="checkbox"/> Other Source (please specify) _____	

PART F: EDUCATIONAL DEBT REPORTING

- List source and amounts of outstanding educational loans used to finance your education.
 - You must submit evidence of the educational debts listed below (i.e. current statements for referenced accounts which include the current balance, account number, your name, and address to which payment is submitted.)
-

1. Lender Name: _____

Lender Address (send payments to): _____

City: _____ State: _____ Zip +4: _____

Account Number: _____ Current Loan Balance \$ _____

2. Lender Name: _____

Lender Address (send payments to): _____

City: _____ State: _____ Zip +4: _____

Account Number: _____ Current Loan Balance \$ _____

3. Lender Name: _____

Lender Address (send payments to): _____

City: _____ State: _____ Zip +4: _____

Account Number: _____ Current Loan Balance \$ _____

4. Lender Name: _____

Lender Address (send payments to): _____

City: _____ State: _____ Zip +4: _____

Account Number: _____ Current Loan Balance \$ _____

5. Lender Name: _____

Lender Address (send payments to): _____

City: _____ State: _____ Zip +4: _____

Account Number: _____ Current Loan Balance \$ _____

6. Lender Name: _____

Lender Address (send payments to): _____

City: _____ State: _____ Zip +4: _____

Account Number: _____ Current Loan Balance \$ _____

PART G: 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 of the completed form are not acceptable.

In addition to this form, please provide a letter of recommendation stating why this applicant is a good candidate for the State Loan Repayment 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, full-time 40 hrs/wk (including a minimum of 32 hours of direct patient care).

* 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.).

I certify that the practice site and/or parent agency will pay half the award amount not to exceed \$25,000 for the first two years of committed service.

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

Name: _____ Title: _____

Signature: _____ Date: _____

Telephone Number: (____) _____ E-mail: _____

PART H: 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 full-time 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.

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

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: