H607.726

INSTRUCTIONS
PRIMARY HEALTH CARE PRACTITIONER
LOAN REPAYMENT PROGRAM
PRACTITIONER APPLICATION FORM

These instructions are to be used to complete the application for participation in Pennsylvania's Primary Health Care Practitioner Loan Repayment Program (Program). Incomplete applications will be returned. Falsification or misrepresentation of facts on this application will disqualify you from participation in the Program.

Deadline Date

All applications and their supporting documentation must be received by the Program Office by the applicable cycle deadline. Practitioner Applications will be reviewed quarterly. Submission deadlines are:

May 15
August 15
November 15
February 15

Complete Application

In order to be a complete application, the following items must be received in this office by the deadline date:

1. Completed Practitioner Application Form.
2. Letter of personal commitment.
3. Curriculum vitae or resume.
4. Three letters of reference.
5. A copy of one completed and signed Loan Information and Verification Form for each lender. The original(s) must be sent to the Lender.
6. Completed Practice Site Application Form signed by an appropriate site administrator. This form is not required when the site appears on our preapproved site list.

If you require any of these items, contact the Bureau of Health Planning, Pennsylvania Department of Health, at (717) 772-5298.

Specific Directions for Completion
of the Practitioner Application Form

1. Complete this section by listing your full name, current home address and telephone numbers, including area code. Place of birth should indicate city and state.

2. Indicate whether loan repayment is an incentive to recruit you to begin work at an approved site in a designated Health Professional Shortage Area (HPSA) or an incentive to retain you at such a site.

3. Place a checkmark next to the applicable discipline.

4. Complete this section by listing the specific street address of the practice site, as well as the city, township or borough in which the site is located. Please include the mailing address if different from the street address. Verify with the site director whether the site is profit or nonprofit.

5. Site approval applications may be obtained by contacting the Department of Health, Bureau of Health Planning at (717) 772-5928 or on our website at www.health.state.pa.us/pco under Primary Care Practice Opportunities.

6. The minimum amount of required service is three years. Preference for participation may be given to individuals who agree to serve in a HPSA for more than three years.

7. Place a check mark next to the appropriate specialty.

8 through 12. Please complete all required information. You may use additional sheets or photocopy portions of the application if additional space is needed.

13. Applicants already obligated for professional practice after completing their academic training must complete that service obligation before becoming eligible for the Pennsylvania Primary Health Care Practitioner Loan Repayment Program.

14. This letter should be a one or two page description that specifically addresses the topics listed in the Application.

15. Three letters of reference, two of which should be from persons who are familiar with your professional work experiences.

16. Complete if fluent in languages other than English.

17. Place a checkmark in the appropriate blank.

18. Read Program Summaries and answer the questions.

19-20. Sign your application and submit it to the address given. **Revised 7/30/09**

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Application for Participation
Pennsylvania Primary Health Care Practitioner
Loan Repayment Program

1. **Applicant Information**

Name:______________________________
Address:____________________________
____

Social Security Number:_______________

Home Phone: (___)___________________
Work Phone: (___)___________________
E-mail: _______________________

Place of Birth: ________________________ Date of Birth: ______________
U.S. Citizen: Yes/No Gender: Male/Female

Please indicate here if your education, employment, or licensure records are under another name.

_______________________	_____________________________
Name	Name

2. **Type of Application**

Recruitment ______ Retention ______

3. **Discipline**

Physician_____	Certified Nurse Midwife _____
Dentist _____	Physician Assistant _____
	Certified Registered Nurse Practitioner _____

4. **Have you selected a practice site?** Yes/No

Name of site: _______________________
Street Address: ______________________
____
Mailing Address (if other than above):
____
____

City/Twp/Boro: ________________
County: ________________________
Telephone: (___)________________

Director:_______________________

Profit_____Nonprofit_____
Solo_____Group_____CHC_____Other_____

5. **Has the site been preapproved?** Yes/No

If the site has not been preapproved, please have the site director submit a practice site application immediately.

6. **Proposed Service Commitment**

Participation in Pennsylvania's Loan Repayment Program requires a minimum of three years of continuous full-time service. Please indicate the proposed length of your service commitment.

Three years_____ Four Years_____

7. **Physicians/Dentists**

Specialty:	Family Practice	_____
	General Internal Medicine	_____
	General Pediatrics	_____
	Obstetrics	_____
	Osteopathic Family Practice	_____
	General Dentistry	_____

8. **License:**

Type:______________________________________
State:___________Number:___________________
Date Issued:_________________________________
Expiration Date:_____________________________
Restrictions:________________________________

Has your license ever been suspended or revoked? Yes/No
Are any professional disciplinary actions pending? Yes/No

If you answered yes to either of the above questions, please attach an explanation to this application.

9. **Are you Board Certified?** Yes/No

Date of Certification:____________________
Name of Board:________________________
Sub-Specialty Board:____________________

10. **Certified Nurse Midwife; Certified Registered Nurse Practitioner; Physician Assistant**

Specialty:	Family Practice	_____
	General Internal Medicine	_____
	General Pediatrics	_____
	Obstetrics	_____

License:

Type:_________________________________
State:______________ Number: __________
Date Issued:___________________________
Expiration Date: _______________________
Restrictions:___________________________

Has your license or certification ever been suspended or revoked? Yes/No
Are any professional disciplinary actions pending? Yes/No

If you answered yes to either of the above questions, please attach an explanation to this application.

11. **Education**

College/Program:____
Address:____
____
From:_________________ To:___________________________
Degree/Diploma: _____________________Discipline: __________
Program Director: _______________________________________
Telephone: (____)____________________

Graduate School: ____
Address:____
____
From: __________________ To: ___________________
Degree:___________________Discipline:____________________
Program Director: ____
Telephone: ____

Medical/Dental School: ______________________________________
Address: ____
From: ___________________ To: _____________________
Degree: ____
Program Director: ___________________________________
Telephone: (____)_____________________________________

12. **Residency Program**

Please list below the information for the residency program most recently completed. If you have completed several residencies, or if your postgraduate training was completed through several programs, attach the required information for these programs to the application.

Residency: ____
Address: ____
____
From: ______________________ To: _________________________
Specialty: ____
Program Director: ____
Telephone: (____)_______________________

13. **Program Eligibility**

Do you have an existing service obligation due to any educational loans received? Yes/No

If yes, please provide the following information. An affirmative answer does not automatically disqualify you from participating in the Loan Repayment program.

Program Name: ____
Address: ____
____
Contact: ____
Telephone: (____)_____________________________
When will this obligation be completed? ________________

Are you in default or breach of contract for the above or any other student loans? Yes/No

If yes, please attach an explanation to this application.

Are there any personal considerations which would limit your ability to relocate? Yes/No

If yes, please attach an explanation to this application.

Are you currently applying for any other source of loan repayment such as the National Health Service Corps (NHSC)? Yes/No

If yes, please attach an explanation to this application.

14. **Describe** your education and practice experience which you believe qualifies you to participate in the Loan Repayment Program. This description should take the form of a letter of personal commitment and must be addressed to:

    Primary Health Care Practitioner Loan Repayment Program
    Pennsylvania Department of Health, Bureau of Health Planning
    Division of Health Professions Development
    Room 1033, Health & Welfare Bldg.
    625 Forster Street
    Harrisburg, Pennsylvania 17120-0701

    Attach the one or two page letter to this application and specifically include the following:

    - Your training and experience in providing services to underserved populations.
    - Practice experience in shortage areas
    - Personal origins or other factors which describe your commitment to practice in a shortage area.
    - Service awards received during your education or practice.
    - Pre-professional experiences which caused you to decide to practice in a shortage area.
    - Physicians and dentists should discuss their commitment to working with physician assistants, certified registered nurse practitioners and nurse midwives. Those other health care practitioners should describe their collaborative practice experience.
    - Please remember to sign this letter.

15. **References**

    Please enclose letters from three references, two of which must be professional, evaluating your professional qualifications, experience and abilities; background and personal characteristics and commitment to providing service in a shortage area. References should be in original form; i.e., bear the original signature of the writer. Letters may not be faxed or e-mailed. All letters must be addressed to The Primary Health Care Practitioner Loan Repayment Program.

16. **Language**

    Please indicate language(s) other than English in which you are fluent.
    ____

17. **Race/Ethnicity**

Although the completion of this section is completely voluntary, preference will be given to minority applicants (check all that apply).

Black or African American	______
Hispanic or Latino	______
White	______
American Indian or Alaska Native	______
Native Hawaiian or Other Pacific Islander	______
Asian	______
Other	______

18. **Division of Health Professions Development Programs**

In addition to Recruitment and Retention Initiatives such as the Loan Repayment Program and Visa Waiver Programs, the Division of Health Professions Development provides funds for Pre-professional and Professional Training/Education programs including the Governor's School for Health Care, Bridging the Gaps Community Health Internship Program, and Pennsylvania Area Health Education Center (AHEC). Please read the following program summaries and answer a few questions about these programs.

a. Governor's School for Health Care - a summer program for honors high school students consisting of an intensive five-week program to provide students with first hand experience in health care careers along with completion of a community health project upon return home.

Did you participate in the Governor's School for Health Care?

____ Yes ____ No

If yes, did participation in this program influence you to practice in an underserved area?

____ Not at all ____ Somewhat ____ A lot ____Deciding factor

b. Bridging the Gaps Community Health Internship Program - Seven-week summer program providing students in the health and social service professions with a collaborative, interdisciplinary, community–based educational experience. Emphasis is placed on health promotion and client education among medically underserved populations.

Did you participate in the Bridging the Gaps Community Health Internship Program?

____ Yes ____ No

If yes, did participation in this program influence you to practice in an underserved area?

____ Not at all ____ Somewhat ____ A lot ____Deciding factor

c. Pennsylvania Area Health Education Center (AHEC) - provides community-based practice experience in primary care for medical students and continuing education to reduce professional isolation and retain health professionals already practicing in rural or underserved areas.

Were any of your rotations arranged through AHEC? ____ Yes ____ No

If yes, did the AHEC rotation influence you to practice in an underserved area?
____ Not at all ____ Somewhat ____ A lot ____Deciding factor

19. **Certification**

I certify that the information given in this application and attachments is accurate and complete to the best of my knowledge. I hereby authorize the Department of Health to contact references and program directors listen in the application for the purposes of obtaining information about my professional qualifications, experience and abilities. I understand that the information I have provided is subject to verification and that providing willfully false information may result in disqualification from participation in this program. I acknowledge receipt of the Loan Repayment Program Bulletin.

Signature:

____

Sign your full name, in ink Date

20. **Submit** your completed application to:

Primary Health Care Practitioner Loan Repayment Program
Pennsylvania Department of Health, Bureau of Health Planning
Division of Health Professions Development
Room 1033, Health & Welfare Bldg.
625 Forster Street
Harrisburg, Pennsylvania 17120-0701

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