



Utah Department of Health  
 Office of Primary Care & Rural Health  
 P.O. Box 142005  
 Salt Lake City, Utah 84114-2005  
 (801) 538-6113 FAX: (801) 538-6387  
 http://health.utah.gov/primarycare

**PHYSICIAN ASSISTANT  
 LOAN REPAYMENT (GRANT) APPLICATION**

**UTAH HEALTH CARE WORK FORCE  
 FINANCIAL ASSISTANCE PROGRAM**

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*The Utah Health Care Workforce Financial Assistance Program Is Administered Without Regard to Race, Color, Religion, National Origin, Sex, Age, or Status as a Handicapped Individual or Disabled Veteran.*

**HEALTH CARE PROFESSIONAL AND EMPLOYMENT SITE APPLICATIONS  
 WILL ONLY BE ACCEPTED BETWEEN APRIL 1 AND JUNE 30 OF EACH YEAR.**

Please note that only health care professionals that have been employed at an employment site for twenty-four (24) months or less, at time of application, will be considered for the Program.

NEW

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**Section I**

**Personal Information**

Name: \_\_\_\_\_  
 (Last) (First) (Middle Initial)

Your Specialty: \_\_\_\_\_

Address: \_\_\_\_\_  
 (Number) (Street) (Apartment/Suite Number)

(City) (State/Province) (Country) (Zip Code)

Telephone Number: HOME:( ) WORK:( )

Email Address: FAX:( )

Social Security Number: \_\_\_\_\_

Place of Birth: \_\_\_\_\_  
 (City) (State/Province) (Country)

Are you a citizen or permanent resident of the United States? Yes  No

Are you fluent in any language other than English? Yes  No

If Yes, please specify: \_\_\_\_\_

Describe, in one page or less, your personal and cultural experiences with underserved populations:

If you need additional space to answer any of the questions in this application,  
 please limit your response to one page per section,  
 and print your name and social security number at the top of each page.

**EVEN IF YOU HAVE ALREADY SELECTED A PRACTICE LOCATION,  
 PLEASE ANSWER ALL QUESTIONS FOR SCORING PREFERENCE AND PRIORITY,**





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**Section II: Education (continued)**

***Preceptorship***

1. Name of Institution where you completed your preceptorship: \_\_\_\_\_

Name of Medical Director/Senior Physician: \_\_\_\_\_

Name of Supervising Physician: \_\_\_\_\_

Supervising Physician's Speciality: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Begin Date: \_\_\_\_\_ Graduation Date: \_\_\_\_\_  
 Month/Year Month/Year

***Examination(s)***

1. National Commission on the Certification of Physician Assistants/National Board of Medical Examiners  
 Physician Assistant National Certification Exam Score:

\_\_\_\_\_ Passed \_\_\_\_\_ Plan to Take \_\_\_\_\_

(Score: \_\_\_\_\_) Month \_\_\_\_ Year \_\_\_\_ Month \_\_\_\_ Year \_\_\_\_

Other (specify what, when, outcome): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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**Section III**

**Professional Experience**

Questions 1 and 2 pertain to any practice experience gained since the completion of your physician assistant training.

1. Outline your professional practice experience over the last five years. Include location, description of setting (solo, group, etc.), length of affiliation with each location, hospital affiliations, and percentage of time expended on providing services associated with Family Medicine, Internal Medicine, Obstetrics, Pediatrics, and Emergency Medicine:

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2. Describe your client profile up to the last five years, including information on age mix, underserved populations, percent of Medicaid patients, and uninsured patients (if known):

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**Section III: Professional Experience (continued)**

3. Employment History: Provide name and contact information of the director or official of each site where you have practiced in the last five years since completing your physician assistant training:

a. Name: \_\_\_\_\_ Title: \_\_\_\_\_

Complete Address: \_\_\_\_\_  
 (Complete Site Name)

Telephone Number:(\_\_\_\_) \_\_\_\_\_ Fax Number:(\_\_\_\_) \_\_\_\_\_

Allocation of Time (Hours per week):

Clinic Care: Administration:\_\_\_\_\_ Clinical/Practice Based:\_\_\_\_\_ Hospital Based:\_\_\_\_\_

Teaching:\_\_\_\_\_ Other (Specify):\_\_\_\_\_

Begin Date:\_\_\_\_\_ End Date:\_\_\_\_\_

Month/Year Month/Year

b. Name: \_\_\_\_\_ Title: \_\_\_\_\_

Complete Address: \_\_\_\_\_  
 (Complete Site Name)

Telephone Number:(\_\_\_\_) \_\_\_\_\_ Fax Number:(\_\_\_\_) \_\_\_\_\_

Allocation of Time (Hours per week):

Clinic Care: Administration:\_\_\_\_\_ Clinical/Practice Based:\_\_\_\_\_ Hospital Based:\_\_\_\_\_

Teaching:\_\_\_\_\_ Other (Specify):\_\_\_\_\_

Begin Date:\_\_\_\_\_ End Date:\_\_\_\_\_

Month/Year Month/Year

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**Section III: Professional Experience (continued)**

4. List states in which you currently hold, or have held, a license to practice as a physician assistant  
 (**Note: You must be eligible to obtain an unrestricted license to practice in the State of Utah.**)

\_\_\_\_\_

5. Have you ever been subject to any disciplinary action or licensure restrictions? Yes  No

If Yes, by whom (Please Explain): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Other Training**

Describe any other pertinent training (Include experience with underserved populations):

1. Location: \_\_\_\_\_  
 (Business Name)

Name of Supervisor/Director: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Complete Address: \_\_\_\_\_  
 (Complete Business Name)

\_\_\_\_\_

Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
 Month/Year Month/Year

Describe Experience: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Section III: Professional Experience (continued)**

2. Location: \_\_\_\_\_  
 (Business Name)

Name of Supervisor/Director: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Complete Address: \_\_\_\_\_  
 (Complete Business Name)

Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
 Month/Year Month/Year

Describe Experience: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Section IV**

**Professional References**

1. Reference Name: \_\_\_\_\_ Position or Title: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

2. Reference Name: \_\_\_\_\_ Position or Title: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

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**Section IV Professional References (continued)**

3. Reference Name: \_\_\_\_\_ Position or Title: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Telephone Number:( \_\_\_\_\_ ) \_\_\_\_\_

**Section V**

**Personal References**

Please give the names and addresses of **THREE (3)** persons, not related to you by blood or marriage, who are qualified to give information regarding your character or financial need.

1. Reference Name: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Telephone Number:( \_\_\_\_\_ ) \_\_\_\_\_

2. Reference Name: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Telephone Number:( \_\_\_\_\_ ) \_\_\_\_\_

3. Reference Name: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Telephone Number:( \_\_\_\_\_ ) \_\_\_\_\_

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**Section VI                      Loan Repayment or Scholarship Service Commitments**

1a. Do you have any existing service obligations?    Yes     No

If Yes, Name of Program: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Contract Entity: \_\_\_\_\_

Telephone Number:(        ) \_\_\_\_\_

Terms of obligation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1b. Are you in default of this or any other obligation?    Yes     No

If Yes, describe circumstances: \_\_\_\_\_

\_\_\_\_\_

2. What date will you be available to begin practice under the Utah Health Care Workforce Financial Assistance Program? \_\_\_\_\_

Month/Day/Year

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**Section VII**

**Practice Preferences**

1. If applicable, please describe preference of practice location in Utah in terms of: type of practice (solo, group, etc.), maximum distance from a hospital, size of community, preferred area in Utah, types of services available in community, climate, geographic features, recreational outlets, etc. *NOTE: If you already have an agreement with a designated Utah practice location, please state name of site location, name of contact person, and nature of your agreement.*

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2. List the most important factors to you when selecting a practice location:

#1 \_\_\_\_\_

#2 \_\_\_\_\_

#3 \_\_\_\_\_

#4 \_\_\_\_\_

3. Describe in one page or less, the characteristics you possess that would make you a good candidate to receive loan repayment for an underserved population practice:

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**Section VII Practice Preferences (continued)**

4. If chosen for this Program, are you willing to provide care to Medicaid, and indigent patients?  
 Yes  No
5. How many years of service are you willing to commit? 2 years  3 years  4 years
6. Please list any other competencies or awards not referred to in this application:

**Please include a copy of your curriculum vitae and State of Utah license along with this application.**

**CERTIFICATION**

I certify that the information I have provided in this application is accurate and complete to the best of my knowledge and belief. I understand my responses may be investigated and any willfully false representation is sufficient cause for rejection of this application.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Sign Full, Legal Name - - In Ink)



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**INFORMATION RELEASE**

I Am Applying for an Educational Loan Repayment or Scholarship Grant Through the Utah Health Care Workforce Financial Assistance Program.

I Consent to the Release to the Utah Department of Health Private, Sensitive, Privileged, and Otherwise Confidential Information about Me to the Extent That it Bears upon Any of the Following: My Education; Internship, Postgraduate, Preceptorship, or Residency Speciality Training; Board Certification; Experience; Professional Conduct; Ethics; Ability to Work with Others; Hospital and Other Affiliations; Disciplinary Actions; Malpractice Claims History; Litigation Experience; State Licensure; and Controlled Substance Licensure. I Intend That this Consent Include All Information That Reflects on My Ability to Safely, Competently, and Professionally Perform the Professional Activities Required of Me Should I Receive a Grant or Scholarship under this Program.

I Agree That this Consent Extend to All Persons, Institutions, and Entities That Have Such Information about Me, Including: Colleges, Universities, Professional Societies, Hospitals, Speciality Boards, Practice Groups, Clinics, Insurance Companies, Partnerships, Professional Corporations, and Employers, and to Persons and Committees Associated with Any of These. I Also Give My Consent for All Such Persons, Institutions, and Entities to Express Their Evaluation of Me and Make Recommendations about My Professional Skill, Conduct, and Ability to Perform Clinical Duties in the Area for Which I Have Applied.

I Intend That a Copy of this Document May Be Relied upon as If it Were the Original.

Legal Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Applicant: \_\_\_\_\_  
 (Type or Print Clearly)

Social Security Number of Applicant: \_\_\_\_\_  
 (Type or Print Clearly)



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**Section VIII**

**Loan Information**

- 1. **Complete Section A.** Return this Section to this Program at the Address Listed Above.
- 2. **Complete and Send Section B.** to Your Lender, Or, Have Your Lender Send a Copy of the Loan Information Directly to this Program, Indicating the Total Unpaid Principal Balance; and for Each Loan, the Disbursement Date and the Type of Loan.

*If Section B Is Filled Out, Be Sure to Write Your Name and Social Security Number on the Form.*

- 3. An Application Cannot Be Processed until Section B, or the Information from the Lender(s) Is Received by Us.
- 4. You Are Responsible for Following up with Your Lender to Assure That the above Information Is Sent.
- 5. If Your Educational Loans Have Been Sold to Another Lender, or Consolidated by a Loan Marketing Association, Submit the Request for Loan Information to **That Lender**, Not to Your Original Lender.
- 6. To Assure That Section A and Section B Can Be Matched upon Receipt, Please Write the Academic Period Covered by the Loan in the Upper Right Corner of Section B.

**Section A.**

Name of Lending Institution: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Purpose of Loan: \_\_\_\_\_

Type of Loan: \_\_\_\_\_

Address Where Payments Are Sent (If Different from Above): \_\_\_\_\_

**Warning**

Any Person Who Knowingly Makes a False Statement or Misrepresentation in this Loan Repayment Application, Fraudulently Obtains Repayment for a Loan, or Commits Any Other Illegal Action in Connection with this Transaction Is Subject to a Fine or Imprisonment. I Have Read this Statement and Understand its Contents.



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**Section VIII: Loan Information (continued)**

Amount of this Loan You Are Requesting to Have Repaid by this Program: \$ \_\_\_\_\_

Academic Period Covered by this Loan from \_\_\_\_\_ To \_\_\_\_\_  
 ((Month/year)) ((Month/year))

Loan Disbursement Dates (If Known): \_\_\_\_\_

**Note:** Loans Without Appropriate Documentation, Loans Paid in Full, Delinquent Loans, and Loans from Friends or Relatives Which Are Undocumented by a Contract Notarized at the Time of the Making of the Loan, **May Not** Qualify for Repayment under this Program.

**Certification by Applicant/borrower**  
 (Must Be Notarized)

I Apply to Enter into an Agreement with the State of Utah for Repayment of All or Part of My Educational Loans Submitted with this Application. Repayment May Be Made Only for Educational Expenses Defined in the Utah Health Care Workforce Financial Assistance Program Rule as Tuition, Fees, Books, Supplies, Educational Equipment and Materials, and Reasonable Living Expenses. I Authorize the Lender(s) Named above to Release Information on My Loan(s) to the Administrator of the Utah Health Care Workforce Financial Assistance Program.

\_\_\_\_\_ )  
 State of Utah ) Applicant's Signature  
 )  
 County of \_\_\_\_\_ )  
 )

On this \_\_\_\_\_ Day Of \_\_\_\_\_, 20\_\_\_\_\_,  
 \_\_\_\_\_ Personally Appeared Before Me,  
 \_\_\_\_\_, A Notary Public, and Signed this Application,  
 Of Which this Acknowledgment Forms a Part.

\_\_\_\_\_ )  
 ) Notary Public  
 )  
 \_\_\_\_\_ )  
 ) Residing at  
 My Commission Expires on \_\_\_\_\_



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**Section B.**

**Loan Data and Certification**  
 (To Be Completed by Lender)

Applicants Social Security Number: \_\_\_\_\_

\_\_\_\_\_ Is Applying for a Grant to Repay Educational Loans  
 (Applicants Name)

Through the State of Utah's Utah Health Care Workforce Financial Assistance Program. Please Provide the Program with the Information Requested Below.

1. Original Amount of Loan:\$ \_\_\_\_\_
2. Current Balance:\$ \_\_\_\_\_ Date of this Balance: \_\_\_\_\_  
 (Month/year)
3. Interest Rate: \_\_\_\_\_% Simple Interest? Yes  No
4. If Other than Simple Interest, Explain: \_\_\_\_\_

5.

Disbursement Date		Type of Loan (E.g. Subsidized Stafford)		Amount for <u>Each</u> Loan That You Service	
Date		Type		Amount	\$
Date		Type		Amount	\$
Date		Type		Amount	\$
Date		Type		Amount	\$
Date		Type		Amount	\$
Date		Type		Amount	\$
Date		Type		Amount	\$

3. Is Any Loan (Or Loans) Listed above in Default?  Yes  No

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**Section B. (Continued)**

**Loan Data and Certification**

(To Be Completed by Lender)

**Lender's Certification**

The Undersigned States That, to the Best of His/her Knowledge, the Loan(s) Identified in this Section Is a Bona Fide, Legally-enforceable Loan(s) Made for the Purpose of Meeting the Borrower's Cost of Attending a School or Institution where they obtained their Physician Assistant Training.

Name of Lending Institution: \_\_\_\_\_  
 (Please Print)

Complete Address of Lending Institution: \_\_\_\_\_  
 (Number) (Street) (Suite Number)

\_\_\_\_\_  
 (City) (State/province) (Country) (Zip Code)

Telephone Number:( \_\_\_\_\_ )

Fax Number:( \_\_\_\_\_ )

Name/title of Officer: \_\_\_\_\_  
 (Please Print)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Return this Completed Form To:  
 Office of Primary Care and Rural Health  
 Utah Department of Health  
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 Telephone: (801) 538-6113 Fax: (801) 538-6387

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### Check List:

Have You Included Each of the Following?  
If Not, Your Application May Be Delayed or Denied.

Please Assure That Each of the Boxes below Are Checked and this Check List Is Returned with Your Completed Application.

- Have All Sections of the Grant Application Been Completed? Sections "Not Applicable" Should Have Been Marked "Na." If Not, Your Grant Application May Be Delayed or Denied.
- Submit a **Completed** Application for Educational Loan Repayment to the Utah Department of Health, Including:
  1. personal Information and
  2. loan Certification.
- A Copy of Your Curriculum Vitae **must** Be Included in Your Application.
- Be a Physician Assistant Who Has a License in Good Standing to Practice in the State. You **must** Provide a Copy of Your Current, Unrestricted License to Practice in the State of Utah.
- Be Available to Begin Service, at an Eligible Employment Site Within One Month of Entering into a Contract with the Utah Department of Health.
- Provide the Utah Department of Health with Documented Evidence of Employment. A Copy of Your Signed Contract or Signed Employment Agreement with the Employment Site **must** Be Provided.
- The Information Release Form of this Application **must** Be Signed and Dated.
- Please Note:** You Are Responsible for Following up with Your Lender to Assure That the Information Is Sent.
- Submit All Documentation Together. Incomplete Applications Will Be Returned. When All Materials Have Been Submitted, Funding Priority Will Then Be Assigned.
- Complete Applications must Be Submitted by the Following Due Date: **Between APRIL 1 and JUNE 30 OF EACH YEAR Only**. Applications Not Received by the Due Date Will Not Be Processed.

Note: Loan repayment grants are subject to federal, state, and local taxes.  
If you have additional questions, please consult a tax professional.