UTAH DEPARTMENT OF HEALTH
OFFICE OF PRIMARY CARE & RURAL HEALTH

Rural Physician Loan Repayment Program

Please Print

*If additional space is needed to answer any of the questions, limit your response to one page per section and print your name and social security number at the top of each page.

Section I Personal Information

Name: _____ D.O. ☐ M.D. ☐
(Last) (First) (M.I.)

Your Specialty: _____

Address: _____
(Number) (Street) (Apartment/Suite)

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

Phone number: Home: (_____)_____ Work/Cell: (_____)_____

Email address: _____

Social Security number: _____

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: _____

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Section II **Education**

Undergraduate Education

Name of Institution: _____

Address:_____

_____

Begin date: _____ Graduation date: _____
(Month/Year) (Month/Year)

Degree(s) obtained: _____

Medical School Education

Name of Institution: _____

Address:_____

_____

Begin date: _____ Graduation date: _____
(Month/Year) (Month/Year)

Title of Degree(s) obtained:_____

_____

Postgraduate Training

Name of Institution: _____

Name of Program Director: _____

Address:_____

_____

Begin date: _____ Graduation date: _____
(Month/Year) (Month/Year)

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Degree(s) obtained: _____

Additional Postgraduate Training Including Fellowships *(Please list separately any other professional training locations.) Add additional pages if needed.*

Name of Institution where you completed residency:_____

_____

Affiliated with what University or Medical Program:

_____

_____

Name of Program Director: _____

Address:_____

_____

Begin date: _____ (Month/Year) Graduation date: _____ (Month/Year)

What is (are) your Specialty(ies):

_____

_____

Are you: Board Certified: Yes ☐ No ☐ Board Eligible: Yes ☐ No ☐

In which specialty(ies) are you Certified?:_____

_____

In which specialty(ies) are you eligible to be Certified?: _____

_____

If Applicable, Year certified: _____

If Applicable, Year recertified: _____

Sub-Specialty, if any: _____

_____

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Section III **Professional Experience**

1. Outline your professional practice experience over the last five years; including location and description of setting (solo, group, etc.).

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

2. List states in which you currently hold or have held a license to practice medicine. (You must be eligible to obtain an unrestricted license to practice in the State of Utah in order to qualify for this program.)

_____
_____

3. Have you ever been subject to any disciplinary action or licensure restrictions?

Yes ☐ No ☐

If yes, by whom? Please explain:

_____
_____

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Section IV **Professional References**

1.
Reference Name: _____

Position or Title: _____

Address:

_____

_____

2.
Reference Name: _____

Position or Title: _____

Address:

_____

_____

3.

Reference Name: _____

Position or Title: _____

Address:

_____

_____

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Section V **Loan Repayment or Scholarship Service Commitment**

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

If yes, please list the name of that program: _____

Address: _____
_____

Contract Entity: _____

Phone number: (_____) _____

Terms of obligation:_____
_____
_____
_____

Are you in default of this or any other obligation? Yes ☐ No ☐

If yes, describe the circumstances: _____
_____
_____
_____

What date will you be available to begin practicing under the Rural Physician Loan Repayment Program? _____

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Section VI **Practice Preferences**

Please include information on the practice location in Utah in which you are applying for loan repayment.

Name of Practice Location: _____

Name of Sponsor Hospital: _____

Name of Hospital Administrator: _____

Address: _____
(Number) (Street) (Suite Number)

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

Phone Number: (_____) _____ Fax Number: (_____) _____

Do you currently have a signed loan repayment contract with this hospital? If yes, please provide a copy.

Yes ☐ No ☐

Please include information on the allocation of time at the practice location in Utah in which you are applying for loan repayment.

Is the position in which you are requesting funding a full-time position? Yes ☐ No ☐

If no, please provide the number of hours per week and your full time equivalency (FTE) status at the practice preference site, i.e. 0.75 FTE, 30 hours per week.

_____ Hours per week

_____ FTE, as determined by the employment site.

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Please include a copy of your State of Utah license along with this application.

APPLICANT CERTIFICATION

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 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 verified and any false representation is sufficient cause for rejection of this application.

Signature of Applicant: _____Date:_____

Printed name of Applicant: _____

INFORMATION REALEASE

I am applying for educational loan repayment through the Utah Rural Physician Loan Repayment Program under Utah Code Ann. § 26-46a-103.

I consent to the release to the Utah Department of Health of private, sensitive, privileged and otherwise confidential information about me to the extent that it bears up any of the following: my education; internship, postgraduate, preceptorship, or residency specialty 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; controlled substance licensure; and any other information that may relate to information provided on this application. 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 contract under this program.

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I agree that this consent extend to all persons, institutions, and entities that have such information about me including: colleges, universities, professional societies, hospitals, specialty 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 and to release that information to the Utah Department of Health.

Signature of Applicant: _____Date:_____

Printed Name of Applicant: _____
(Print Clearly)

Social Security number of Applicant: _____
(Print Clearly)

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LOAN INFORMATION

Return Section A to the Utah Department of Health.
Office of Primary Care and Rural Health
3760 South Highland Drive, Suite 404
P.O. Box 142005
Salt Lake City, Utah 84114

Or;

opcrh@utah.gov

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 for each loan, the disbursement date and type of loan.

An application cannot be processed until Section B or the information from the lender(s) is received by the Utah Department of Health.

You are responsible for following up with your lender to assure that the above information is sent.

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 your original lender.

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.

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Section A.

Name of Lending Institution: _____

Address of Lending Institution: _____
_____

Phone number: (____)_____ Fax number (____)_____

Purpose of Loan: _____

Type of Loan: _____

Address where payments are sent: _____
_____

Amount of loan you are requesting to have repaid by this program (dependent on the contract with sponsoring Hospital, up to $15,000): $_____

Academic period covered by this loan: _____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.*

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I hereby certify that I am applying 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 Rural Physician Loan Repayment Program Rule, Utah Admin. Code R434-45, as allopathic or osteopathic medical education, including books, equipment, fees, materials, reasonable living expenses, supplies and tuition.

I authorize the lenders named above to release information on my loans to the administrator of the Rural Physician Loan Repayment Program at the Utah Department of Health.

_____
Applicant Signature

State of Utah)
SS)
County of _____)

On this_____ Day of _____, 20_____,

_____ personally appeared before me,

_____, a Notary Public, and signed this Application, of which this acknowledgement forms a part.

_____
Notary Public

_____
Residing at

My Commission expires on _____

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Section B.

Academic period covered by the loan:_____

Loan Data and Certification

(Completed by Lender)

Applicant Social Security number: _____
is applying for a contract to repay educational loans through the State of Utah's Rural Physician Loan Repayment Program. Please provide the State of Utah Rural Physician Loan Repayment Program with the information requested below.

1. Original loan amount: $_____
2. Current balance: $_____ Date of this balance: _____
3. Interest Rate: _____% Simple Interest? Yes ☐ No ☐
4. If other than simple interest, please explain: _____
5.

Disbursement date		Type of Loan (e.g. Subsidized Stafford)		Amount for each loan that you service	
Date		Type		Amount	$
Date		Type		Amount	$
Date		Type		Amount	$
Date		Type		Amount	$
Date		Type		Amount	$
Date		Type		Amount	$

6. Is any loan (or loans) listed above in default? Yes ☐ No ☐

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Lender's Certification

The undersigned states that, to the best of his/her knowledge, the loans(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 Allopathic or Osteopathic education.

Name of Lending Institution: _____
(Please Print)

Address of Lending Institution: _____
(Number) (Street) (Suite Number)

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

Phone number: (____) _____ Fax number (____) _____

Name/Title of Officer: _____
(Please Print)

Signature: _____ Date: _____

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Application Checklist

Be sure that each of these items is complete.

1. **Complete all sections of the application. Any section that is "not applicable" should have been marked N/A. If all sections are not completed, your application may be delayed or denied.**

2. **Submit a completed application to the Utah Department of Health, Rural Physician Loan Repayment Program including:**
   - **Personal Information**
   - **Loan Certification**

3. **Submit a copy of the signed Loan Repayment contract with the approved rural hospital.**

4. **Provide a copy of your current, unrestricted license to practice medicine in the State of Utah. You must be a physician who has a license in good standing to practice in the State of Utah.**

5. **Submit the signed and dated information release form with this application.**

6. **Follow up with your lender to assure that the information is sent.**

7. **Submit all documentation together to OPCRH@utah.gov with "RPLRP Application" in the subject line.**