SAMPLE

EXCEPTIONAL FINANCIAL NEED (EFN), FINANCIAL ASSISTANCE FOR DISADVANTAGED HEALTH PROFESSIONS STUDENTS (FADHPS) AND PRIMARY CARE LOAN (PCL) PROGRAMS POST-RESIDENCY CERTIFICATION FORM

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As an EFN and FADHPS recipient you are required to practice primary health care for 5 years after completion of residency.
As a PCL recipient you are required to practice primary health care until your loan is repaid in full. Please complete and return this form to us in the enclosed envelope.

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NAME

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HOME ADDRESS

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PHONE NUMBERS

(___)__________(WORK)
(___)__________(HOME)

WORK ADDRESS

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CURRENT PRACTICE STATUS:

__ FAMILY MEDICINE
__ GENERAL INTERNAL MEDICINE

__ GENERAL PEDIATRICS
__ PREVENTIVE MEDICINE

__ OSTEOPATHIC GENERAL PRACTICE
__ GENERAL DENTISTRY

COMMENTS:____
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I CERTIFY THAT THE INFORMATION CONTAINED ON THIS CERTIFICATION FORM IS ACCURATE AND THAT I AM IN COMPLIANCE WITH THE OBLIGATIONS SPECIFIED IN MY EFN/FADHPS AGREEMENT(S) AND/OR PRIMARY CARE LOAN PROMISSORY NOTE FOR PRIMARY HEALTH CARE SERVICE.

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SIGNATURE DATE

RETURN COMPLETED FORM TO: