MEDICAL STUDENT LOAN PROGRAM
REQUEST FOR POSTPONEMENT OF LOAN PAYMENTS

NAME OF BORROWER_____
(Please List Full Name)

TELEPHONE/CELL PHONE_____**SOCIAL SECURITY NUMBER** _____

HOME ADDRESS _____
(Street Address)

_____
(City) (State) (Zip Code)

EMAIL ADDRESS: _____

I anticipate beginning practice in the field of _____ on or about _____, 20____. I will be in _____private practice or will be _____an affiliate of _____in _____, West Virginia.
(Location of Service)

I understand that should the aforementioned practice location and/or the aforementioned practice specialty qualify as an approved designated medically underserved area or an approved designated medical specialty in which there is a shortage of physicians in West Virginia and should I practice full-time in such approved area or approved specialty for a period of twelve (12) consecutive calendar months, that I will be eligible to apply for loan forgiveness under the provisions of the West Virginia Higher Education Policy Commission rule, Series 34, Medical Student Loan Program.

I hereby request approval to postpone payments on my Medical Student Loan for the period of twelve (12) consecutive calendar months following the commencement of the aforementioned described practice. I understand that should I fail to fulfill my service obligation of twelve (12) consecutive calendar months of full-time practice in West Virginia as set forth above, the approved postponement will become null and void and I shall be responsible for any payments that were due during the postponement period along with any accrued interest.

Signed_____**Date**_____, 20_____
(Signature of Borrower) (Month/Day) (Year)

NAME OF MEDICAL SCHOOL ATTENDED_____

Send completed form to: Medical Student Loan Program, Coordinator, Senior, West Virginia Higher Education Policy Commission, 1018 Kanawha Boulevard East, Suite 700, Charleston, WV 25301-2800

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WEST VIRGINIA HIGHER EDUCATION POLICY COMMISSION OFFICE USE ONLY

_____**REQUEST APPROVED** _____**REQUEST DENIED**

If denied, reason(s) for disapproval _____

_____

Signed _____ **Date**_____, **20**_____
(Signature of Senior Director of Financial Aid) (Month and Day) (Year)

Copy of document sent to institution on: **Date**_____, **20**_____
(Month and Day) (Year)

Revised September 2014