

MEDICAL STUDENT LOAN PROGRAM

CERTIFICATION OF SERVICE FOR LOAN FORGIVENESS

General Instructions:

This form is to be used by a Medical Student Loan Program recipient to apply for loan forgiveness upon the completion of twelve (12) consecutive months of full-time clinical service in West Virginia in (1) a designated medically underserved area of West Virginia or (2) in a designated medical specialty in which there is a physician shortage in West Virginia. The applicant must have applied for and received prior approval to practice in the specialty or underserved area indicated in this certification in order to be eligible for forgiveness. Loan forgiveness is not authorized for periods of less than twelve consecutive months of practice.

Request for forgiveness should be submitted no later than 120 days after completion of service as indicated in Question 4. Send completed form, including the endorsement of (1) a medical colleague in a supervisory position such as a hospital department head, county health director, etc. and (2) a member of the community who can verify your medical practice in the area during the 12-month period indicated below, to: Administrator, Medical Student Loan Program, Higher Education Policy Commission, 1018 Kanawha Boulevard, East, Suite 700, Charleston, West Virginia 25301.

WARNING: The giving of false information or statements on this certification of service form is a crime under the laws of the State of West Virginia. Conviction thereof shall be a misdemeanor punishable by a fine and/or imprisonment.

1. _____
(Borrower) (Email) (SS#)

2. Indicate School of Medicine from which Medical Student Loan was received.

3. Loan forgiveness is requested for years of practice from _____ 20_____ to _____ 20_____.

4. Forgiveness is requested for practice in (check one)
a. _____ a medically underserved area or
b. _____ a designated specialty.

5. In what specialty are you practicing? _____.

6. Where did you maintain a full-time clinical practice during the period designated in Question 4? _____

7. Practice Name: _____

8. Address: _____

9. Telephone: _____

10. Borrower(s) Medicare Provider Number: _____

11. Borrower(s) Medicaid Provider Number: _____

12. Please indicate the office hours you maintain during the reporting period. Please designate A.M. or P.M. Use "X" for days when you were not usually practicing.

Sun ____ Mon ____ Tues ____ Wed ____ Thurs ____ Fri ____ Sat ____

From: _____ To: _____

13. Please indicate the approximate number of hours you spent each week in the treatment of hospitalized patients of the practice.

14. _____ check here if you are requesting approval to continue to practice in this location and specialty for loan forgiveness and another twelve-month postponement of loan payments.

CERTIFICATION

I certify that the above reported information is correct to the best of my knowledge and accurately reflects my activities relating to the fulfillment of my record of clinical practice in support of forgiveness of all or a portion of my indebtedness to the Medical Student Loan Program.

(Borrower(s) signature) Date: _____

(Print or type Borrower(s) Name) Telephone: _____

Address: _____

I, _____ a Notary Public for the State of West Virginia, County of _____, do certify that _____ appeared before me this _____ day of _____ 20_____ and duly signed the above document.

Signed _____ My commission expires _____, 20_____.

ENDORSEMENT

I have reviewed the above information submitted by _____

And, to the best of my knowledge, he/she did practice medicine during the reported time period and in the specialty and at the location indicated.

(Signature of Health Official) Date: _____ 20 _____

(Printed Name of Health Official) Title: _____

(Agency or Institution) Telephone: _____

Address: _____

(Signature of Member of Community) Date: _____ 20 _____

(Printed Name of Member of Community) Title: _____

(Agency or Institution) Telephone: _____

Address: _____

FOR HIGHER EDUCATION POLICY COMMISSION OFFICE USE

_____ Approved forgiveness request _____ Disapproval forgiveness request

If disapproved, reason for disapproval _____

Signed: _____ Date: _____ 20 _____
(Signature of Senior Director of Financial Aid)

Copy of document sent to lender on _____, 20_____