MEDICAL STUDENT LOAN PROGRAM

CERTIFICATION OF SERVICE FOR LOAN FORGIVENESS

GENERAL INSTURCTIONS:

This form is to be completed by a borrower of the Medical Student Loan Program who is seeking loan forgiveness by virtue of the fulfillment of twelve (12) consecutive months of full-time clinical service in West Virginia in (1) an approved designated medically underserved area or (2) an approved designated medical specialty in which there is a shortage of physicians. The borrower should have applied for and obtained Commission approval prior to the beginning of practice at the approved designated medically underserved area and/or in an approved designated medical specialty in which there is a shortage of physicians that is indicated in this certification to be eligible for loan forgiveness.

Request for loan forgiveness should be submitted no later than one hundred twenty (120) days after fulfillment of the service commitment as indicated in Question #4. However, no form will be processed should the date of the borrower's signature precede the end date of the service period as shown in Question #4 or omission of any information requested such as notarization and/or endorsements. The endorsements must consist 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 the existence of the medical practice at the designated location during the twelve (12) month period as indicated in Question #7.

1. NAME OF BORROWER_____

2. SOCIAL SECURITY NUMBER OF BORROWER_____

3. INDICATE SCHOOL OF MEDICINE FROM WHICH BORROWER RECEIVED MEDICAL STUDENT LOAN

_____

4. LOAN FORGIVENESS IS REQUESTED FOR YEAR OF PRACTICE FROM _____, 20 ____ ,
(Month and Day) (Year)

to _____, 20 _____
(Month and Day) (Year)

5. LOAN FORGIVENESS IS REQUESTED FOR PRACTICE. (CHECK QUALIFYING CONDITION(S)

☐ an approved designated medically underserved area in West Virginia and/or

☐ an approved designated medical specialty in which there is a shortage of physicians in West Virginia

6. PLEASE SPECIFY THE DESIGNATED MEDICAL SPECIALTY THAT YOU ARE PRACTICING

_____

7. PLEASE INDICATE THE NAME AND LOCATION OF YOUR FULL-TIME CLINICAL PRACTICE DURING THE PERIOD DESIGNATED IN QUESTION #4

Name of Practice Facility: _____

Address of Practice Facility: _____

City and State: _____ Telephone # _____

8. BORROWER'S MEDICARE PROVIDER NUMBER _____

9. BORROWER'S MEDICAID PROVIDER NUMBER _____

10. 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. Full-time is considered thirty-two (32) hours per week.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From:							
To:							

11. PLEASE INDICATE THE APPROXIMATE NUMBER OF HOURS PER WEEK THAT YOU SPENT IN THE TREATMENT OF HOSPITALIZED PATIENTS OF THE PRACTICE _____

12. ☐ PLEASE CHECK TO REQUEST APPROVAL FOR CONTINUED PRACTICE AT THE CURRENT LOCATION AND/OR MEDICAL SPECIALTY IN ORDER TO QUALIFY FOR ANOTHER TWELVE (12) MONTH POSTPONEMENT OF LOAN PAYMENTS AS WELL AS ANOTHER YEAR OF LOAN FORGIVENESS SHOULD THE SERVICE COMMITMENT BE FULFILLED.

13. CERTIFICATION:

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

_____ Date: _____, 20 _____

(Borrower's Signature) (Month and Day) (Year)

_____ _____

(Print or Type Borrower's Name) Borrower's Telephone/Cell #)

_____

(Street Address)

_____, _____ _____

(City) (State) (Zip Code)

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.

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

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NOTARIZATION

I, _____, a notary Public of 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 _____.

(Month and Day) (Year)

ENDORSEMENTS

I have reviewed the above information submitted by _____
(Name of Borrower)
and, to the best of my knowledge, he/she did practice medicine during the reported time period in the medical specialty and at the location indicated.

1. _____, _____ , 20 ____
(Signature of Health Official) (Month and Day) (Year)

_____, _____
(Printed Name of Health Official) (Title)

_____, _____
(Name of Agency or Institution) (Telephonel Number)

_____ _____
(Street Address)

_____, _____ _____
(City) (State) (Zip Code)

2. _____, _____, 20 _____
(Signature of Community Member) (Month and Day) (Year)

_____, _____
Printed Name) (Title)

_____
(Street Address)

_____, _____, _____, _____
(City) (State) (Zip Code) (Telephone/Cell Number)

****

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)