



2016 LOAN REPAYMENT PROGRAM APPLICATION

Ohio Dental Hygienist Loan Repayment Program
 Ohio Dentist Loan Repayment Program
 Ohio Physician Loan Repayment Program
 State Loan Repayment Program

Date Application Received by ODH

I. Applicant Information

Name								
Last	First	MI	Maiden				Home Phone	
Home Address							Cell Phone	
City			State		Zip+4		E-mail	
Home County			Place of Birth			Date of Birth		
Race (select all that apply)				Ethnicity (select only one)			Languages Spoken (other than English)	
White Black or African American American Indian/Alaskan Native Asian Native Hawaiian/Other Pacific Islander Other				Hispanic, Latino or Spanish Origin Not Hispanic, Latino or Spanish Origin				
Geographic Background							U.S. residency status	
City	State	Rural	Inner City	Appalachian	Other	Ages	U.S. Citizen U.S. National Legal Alien Other	
						to		
						to		
						to		
Are you a veteran of the U.S. Armed Forces?				Ohio License Number			Ohio Medicaid Number (if applicable)	
Yes				No				
Discipline							National Provider Identifier (NPI) (if applicable)	
Physician		Dentist		Registered Dental Hygienist		Other		
Specialty (select all that apply)							Current employment contract (if applicable)	
Adolescent Medicine			General IM		IM/PEDS		Start Date:	
Child/Adolescent Psych			Geriatric Psych		OB/GYN		End Date:	
Family Practice			Geriatrics		Pediatrics			
General Psych			GPR/AEGD		Other		If in residency training, date available to practice	

II. Education and Credentials

Health professions school/training program: Dates of Attendance: through	City/State: Date of graduation
Residency Program: Dates of Attendance: through	City/State: Date of graduation:
Any additional training programs: Dates of Attendance: through	City/State: Date of completion:
Current Status (<i>select one</i>) Enrolled in final year of training program or residency Practicing in Ohio Practicing outside of Ohio Not currently in practice	Credentials (<i>required before beginning the program</i>) List State(s) where you currently hold a license or certification:
Are you Board certified or eligible? Yes No Pending N/A	Note any licensure restrictions (<i>if applicable</i>)

III. Obligations

Note: All applicants who have an outstanding contractual obligation for health professional service to the Federal Government (e.g., an active military obligation), a State (e.g., Loan Repayment, Scholarship or MEDTAPP Program) or other entity are ineligible to participate in Ohio's health professional loan repayment programs unless that service obligation will be completely satisfied before a loan repayment contract with the state of Ohio begins. Be aware that certain clauses in employment contracts may impose a service obligation. See application instructions for additional information.

A. Did you apply to the National Health Service Corps Loan Repayment Program this year?	Yes	No
B. Do you have a Primary Care Loan from the Health Resources and Services Administration through your medical school?	Yes	No
C. Are you a member of a Reserve Component of the Armed Forces or National Guard?	Yes	No
D. Do you have an existing service obligation?	Yes*	No

****If yes, please complete the following:***

Name/Description of obligation		
Contact person	Telephone	Completion date
Terms of obligation		
Are you in default on this obligation?		Yes No

IV. Background and Biographical Statements

On a separate document, respond to all of the following requests. Label each section to correspond with the letters and numbers below:

- A. Describe your and your spouse's/partner's geographic background. Include the names of your hometowns, what it was like growing up there, and any time spent in Appalachian, rural or inner city communities.
- B. Describe your experience with underserved and diverse populations. Include student, volunteer and work experiences and detail the following information for each experience:
 - 1) Name of program, if applicable, and whether the experience was required for school/training;
 - 2) Year and length of experience, including average time commitment per week;
 - 3) Location of experience and brief description of services provided;
 - 4) Knowledge, skills and abilities gained from the experience; and
 - 5) Results of experience (e.g., development of community programs, awards, published articles, etc.).
- C. Provide two to four professional goals related to your practice in an underserved area.
- D. Describe your and your family's interest in living and working in an underserved area.
- E. Share language skills, including level of proficiency (if any), that you use or will use to provide services to the patient population of the practice site.
- F. List any experience you have with National Health Service Corps programs (SEARCH, Scholarship or Loan Repayment).
- G. Provide any additional knowledge, skills and abilities that will be incorporated into your practice to improve the delivery of health services to the population of the community where the practice site is located. Consider the values, beliefs and practices of the patient population.

V. Certification and Acknowledgement

- A. I certify that the information given in the application is accurate and complete to the best of my knowledge and belief. I understand that it may be investigated and that any willfully false representation is sufficient cause for the rejection of this application.

Applicant's signature

Date

- B. I acknowledge that I have read the Application Information and understand that if selected for a loan repayment contract, I will be obligated to remain at the practice site(s) for a minimum of two years. I also understand that failure to uphold the requirements of a loan repayment contract could result in significant financial consequences.

Applicant's signature

Date

