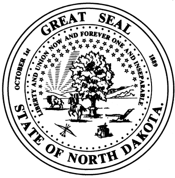

DENTIST LOAN REPAYMENT GRANT PROGRAM APPLICATION

ND Department of Health
Primary Care Office
SFN 59242 (10-2009)

Dept. Use Only
File Number:

Telephone: 701.328.2353

Name of Dentist				
Home Address	City	State	Zip Code	Home Phone
Office Address	City	State	Zip Code	Office Phone
Other Address and Phone where I can be contacted:	City	State	Zip Code	Cell Phone: E-Mail address:

I prefer to be contacted at ☐ Home ☐ Office ☐ Other ☐ Any of the three

Identify your specialty

_____ General Dentistry _____ Orthodontics _____ Oral & Maxillofacial Surgery _____ Prosthodontics

_____ Pediatric Dentistry _____ Oral Pathology _____ Periodontics ______Endodontics

_____ Other, please specify:

TRAINING

Dental School	Year of Graduation
Externship	Year of Completion
Residency	Year of Completion
Post Graduate	Year of Completion

Regional Board Exam Taken (Date) National Board Exam Taken (Date)

(specify region)

Current Status

☐ Practice ☐ Teaching ☐ Administration
☐ Other

North Dakota License Number or date Exam will be Taken:

Practice Experience	Location	Type	Years

Hospital Privileges	Location	Type	Years

OUTSTANDING DENTAL EDUCATION LOANS

Lender/Address	Loan #	Amount	Balance	Date Loan Must Be Paid

Are you in default on any loans? If yes, identify loan and amount.

How much money are you requesting? (You may request no more than $60,000)

Name of North Dakota Dental Clinic where you will practice	Date you will be able to begin

Have you signed a three year or longer employment contract with your employer?

_______ Yes   ______No

Do you have a dental license in any state or country other than North Dakota?
If yes, please specify.

Are you currently in litigation? If yes, please explain.

EMPLOYMENT HISTORY (List most recent employer first)		
Employer	Address	Dates Employed

My Clinic will bill my patients according to a sliding fee schedule.

Yes ☐ No ☐

1. Attach three letters of recommendation.
2. Attach a copy of your North Dakota dental license.
3. Attach a letter of support from the dental clinic where you will serve.

SIGNATURES AND AFFIDAVIT

The undersigned hereby makes application for a dental loan repayment subject to the provisions of North Dakota Century Code Chapter 43-28.1 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health.

____ ____________________
Signature Date

State of ________________________________)
) ss
County of _______________________________)

On this __________________ day of ________________________, year ________, before me personally appeared ____ who having been sworn states that to the best of his/her knowledge and belief the statements in the foregoing application are true.

____
Notary Public

(Seal)

My commission expires ________________________

Return the completed application to:

Gary Garland, Director
Primary Care Office
North Dakota Department of Health
600 East Boulevard Ave Dept 301
Bismarck ND 58505-0200