



**PHYSICIAN STATE/COMMUNITY MATCHING
LOAN REPAYMENT PROGRAM
REQUEST FOR REIMBURSEMENT**

ND Department of Health
Division of Health Facilities
SFN 51140 (8-2001)

Telephone: 701-328-2352

<u>Dept. Use Only</u> File Number: Contract Number:

Name of Physician			
Name of Community			
I am requesting reimbursement from the Physician Loan Repayment Program per Chapter 43-17.2 of the North Dakota Century Code. I have completed the required six (6) months of full-time service to the community and I am therefore eligible to receive the first year payment.			
Date the six (6) months of full-time practice completed:		First Year Payment: \$	
Please send my payments to:			
Address	City	State	Zip Code
Signature of Physician		Date	