



FEDERAL STATE LOAN REPAYMENT CONTINUATION APPLICATION

NORTH DAKOTA DEPARTMENT OF HEALTH

FEDERAL STATE LOAN REPAYMENT PROGRAM (SLRP)

SFN 61084 (6-2016)

For Office Use Only

File Number	
Date Received	
Contract Number	
HPSA Yes <input type="checkbox"/> No <input type="checkbox"/>	HPSA Score

Name of Health Professional					
Office Name					
Office Address					
City		State		ZIP Code	
Office E-mail Address			Office Telephone		
Personal E-mail Address			Home/Cell Telephone		
Identify your Discipline					
<input type="checkbox"/> MD	Allopathic Medicine	<input type="checkbox"/> DDS/DMD	General or Pediatric Dentistry		
<input type="checkbox"/> DO	Osteopathic Medicine	<input type="checkbox"/> RDH	Registered Dental Hygienist		
<input type="checkbox"/> NP	Nurse Practitioner	<input type="checkbox"/> HSP	Health Service Psychologist (Clinical and Counseling)		
<input type="checkbox"/> PA	Physician Assistant	<input type="checkbox"/> LCSW	Licensed Clinical Social Worker		
<input type="checkbox"/> CNM	Certified Nurse Midwife	<input type="checkbox"/> PNS	Psychiatric Nurse Specialist		
<input type="checkbox"/> RN	Registered Nurse	<input type="checkbox"/> LPC	Licensed Professional Counselor		
<input type="checkbox"/> PHARM	Pharmacist	<input type="checkbox"/> MFT	Marriage and Family Therapist		
OUTSTANDING EDUCATIONAL LOANS					
Lender/Address	Loan Number	Date of Original Loan	Original Amount of Loan	Current Balance of Loan	Current Interest Rate

PLEASE PROVIDE VERIFICATION FROM YOUR LENDER OF YOUR OUTSTANDING EDUCATIONAL LOANS AND VERIFICATION THAT FUNDS RECEIVED HAVE BEEN APPLIED TO THE LOAN BY SHOWING A PAYMENT HISTORY.

SIGNATURES AND AFFIDAVIT

I hereby make application for a federal state loan repayment award subject to the provisions in the federal state loan repayment program and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health. I also give the North Dakota Department of Health permission to obtain any information from my lender(s) that may be needed to verify the contents of this application; for the North Dakota Department of Health to make payments to my lending institution(s) and for the North Dakota Department of Health to obtain information from the North Dakota University System to determine if any State support payments have been paid on my behalf.

Signature of Applicant

State	County
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Signed and sworn to (or affirmed) before me on	Date
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Name(s) of Individual(s) Making Statement	Affix Notary Stamp
Signature of Notary Public or Other Authorized Officer	
Commission Expiration Date (if not listed on stamp)	

Return the completed form to:

Bobbie Will
Manager of North Dakota Primary Care Office
Office of Public Health Systems and Performance
600 E Boulevard Ave. Dept. 301
Bismarck, ND 58505
Fax 701.328.4727
Office 701.328.4908
blwill@nd.gov