MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

APPLICATION TO RE-CONTRACT
with the
MICHIGAN STATE LOAN REPAYMENT PROGRAM
PART A

Please type or print all information

This form should only be used as part of your application to re-contract with SLRP. SLRP providers must have completed one year of their service obligation before applying to re-contract.

Your Name: _____ Today's Date: ____/____/_____

Information about your current SLRP Contract:

1. Start Date: ____/____/_____.
2. Completion Date: ____/____/_____.
3. Contract Amount: $_____.

You must also submit the follow forms, which you will find on the SLRP website at www.michigan.gov/mislrp:

1. **Part B of the SLRP Provider Application** and **Loan Payment History**
   Part B, along with loan payment history documentation provided by your lenders, must clearly show that your qualifying educational debt has been reduced by the amount of all SLRP payments you have received to date.

   Please note: You will be required to submit payment loan history that clearly shows the your qualifying educational loans were reduced by at least the amount of your total SLRP payments under your current contract before you will receive your first check under an new contract. It is your responsibility to remember to submit this additional loan payment history information to the SLRP Office. Failing to so will result in a significant payment delay.

2. **SLRP Site Application and Declaration of Intent**
   An updated SLRP Site Application and Declaration of Intent completed and signed by your employer. The SLRP Office will review this form to determine if your Practice Site currently is located within a Health Professional Shortage Area and meets all program requirements.

SECTION I: Personal Information

1. Name _____ 2. ____-____-_____ 3. Today's Date:_____
   Last First Middle Social Security #

4. Are you an American citizen? _____Yes _____No

5. Address_____
   _____
   _____
   _____
   City State Zip Code

6. Telephone Numbers:
   Home ( ) _____
   Cell ( )_____
   Work ( )_____
   E-mail _____

7. Do you wish to authorize a spouse or relative to discuss your application in your absence? _____Yes _____ No

   If yes, please print the name of this person: _____

8. RACE: Please mark ONE box to indicate the race group which applies to you:

   A □ Hispanic
   B □ White (except Hispanic)
   C □ Black (except Hispanic)
   D American Indian, Eskimo or Aleut (AIEA)
   E Asian or Pacific Islander (API)

   NOTE: In order to satisfy federal reporting requirements, if you leave this question blank, a race will be reported that reflects Michigan racial demographics. If you leave this question blank, but indicate specific races in the next question below, it will be assumed that those races apply to you equally.

9. Are you MULTIRACIAL*? _____ Yes _____ No
   If you answer "Yes," please mark all of the races below that apply.

   A)□ Hispanic B) □White C) □ Black D) □ AIEA E) □ API

   *For purposes of this question, you are Multiracial if you have parents from more than one of the broad race categories listed above, or if at least one of your parents is Multiracial.

10. Date of Birth: ___/___/_____

11. Age at time of this application: _____
    Age-related information is required for federal reporting and continued federal funding.

Please type or print all information

SECTION II: Practice Information

You must include all requested Practice Site information to be consider for re-contracting with SLRP.

10. SLRP Practice Site Number 1:
_____ Work Phone: ( )_____
_____ Cell Phone: ( )_____
_____ Work Fax:( )_____
_____ Work EMAIL:_____
_____
City State Zip Code

Is this a change from the Practice Site where you completed the first year of your SLRP Service Obligation? (Please check one.) Yes ___ No___

SLRP Practice Site Number 2:
_____ Work Phone: ( )_____
_____ Cell Phone: ( )_____
_____ Work Fax:( )_____
_____ Work EMAIL:_____
_____
City State Zip Code

Is this a change from the Practice Site where you completed the first year of your SLRP Service Obligation? (Please check one.) Yes ___ No___

11. County & Township of Current Practice:_____
County Township

12. Is the above practice site a (check all that apply):
Public or Not-for-profit Private Agency [501 (C)3]_____.
Migrant Health Center_____
Hospital Clinic_____
Offsite Hospital Clinic_____
Community Health Center (FQHC)_____
State, county or City Public Clinic_____
Critical Access Hospital (CAH) _____
CAH-administered clinic_____
Community Mental Health (CMH) clinic_____
Certified Rural Health Clinic _____
State Psychiatric Hospital_____
State-funded Primary Care Clinic_____
State Correctional Facility_____

13. Hours per week served a current practice site : _____

14. Start date in current practice: _____/_____/_____

15. Are you professionally trained to deliver:
a. Prenatal care _____Yes _____No

b. Obstetrical care _____Yes _____No

If the answer to 15 is yes, approximately how many pregnant women do you serve per year? _____

If the answer to 15 is yes, approximately how many deliveries do you perform per year? _____

Please type or print all information

SECTION III: Educational and Professional Information

16. Name and Address of Medical/Nursing/Dental/PA/Graduate School

_____
_____
_____
_____
City State Zip Code

17. Beginning date of medical/graduate/dental education: ____/____/____

Graduation date from medical/graduate/dental education ____/____/____

18. Name and address of residency/PA/ nursing program:

_____
_____
_____
_____
City State Zip Code

19. Completion date of medical residency program: ____/____/____

20. Please provide the License Number (LN) of the specialty you will be employing in this loan repayment agreement:

Medical LN:_____ Dental LN: _____

Psychology LN: _____ SW LN: _____

Nursing LN: _____ Phys. Assnt. LN:_____

21. If you are not licensed in Michigan, identify: State of Licensure: _____

License Number: _____ Specialty: _____

Please type or print all information

22. Specialty (Please check one):

___ Family Practice
___ Obstetrics/Gynecology
___ Pediatrics
___ Internal Medicine
___ Psychiatry
___ Nurse Midwife
___ Nurse Practitioner
___ Dental
___ Psychology/Social Work /PNP
___ Other (specify: _____)

If you are an OBGYN or CNM: Will you be providing prenatal care? Yes____ No____
Will you spend at least 21 hours per week providing Primary care in an ambulatory setting during normally Scheduled office hours? Yes____ No____

SECTION IV: **Loan Information** (Copy this page if you have more than three loans)

23. Please list below, in priority order, all educational loans received during the professional education for which you are eligible to be considered for repayment. Provide <u>lender</u> information.

	Loan 1	Loan 2	Loan 3
Name of Loan	_____	_____	_____
Program Lender Name	_____	_____	_____
Address	_____	_____	_____
	_____	_____	_____
	_____ City, State, Zip Code	_____ City, State, Zip Code	_____ City, State, Zip Code
Principle Remaining	$_____	$_____	$_____
Academic Period Covered by Loans	_____/_____	_____/_____	_____/_____

<u>SECTION V</u>: **Certification**

24. I certify that the information above is true and correct

Signature

Date