



# DENTIST LOAN REPAYMENT APPLICATION

NORTH DAKOTA DEPARTMENT OF HEALTH  
 DENTISTS' LOAN REPAYMENT PROGRAM  
 SFN 53025 (9-2015)

For Office Use Only

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

Name of Dentist				
Home Address	City	State	ZIP Code	Home Telephone Number
Office Address	City	State	ZIP Code	Office Telephone Number
Other Contact Address	City	State	ZIP Code	Other Telephone Number (Cell)
Personal E-mail Address			I prefer to be contacted at <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Other <input type="checkbox"/> Any of the three	
Office E-mail Address				
Other E-mail Address				
Identify your specialty <input type="checkbox"/> General Dentistry <input type="checkbox"/> Pediatric Dentistry <input type="checkbox"/> Orthodontics <input type="checkbox"/> Oral & Maxillofacial Surgery <input type="checkbox"/> Prosthodontics <input type="checkbox"/> Oral Pathology <input type="checkbox"/> Periodontics <input type="checkbox"/> Endodontics <input type="checkbox"/> Other, please specify:				
<b>EDUCATION AND TRAINING</b>				
Dental School			Year of Graduation	
Externship			Year of Completion	
Residency			Year of Completion	
Post Graduate			Year of Completion	
Regional Board Exam Taken (Date) (specify region)			National Board Exam Taken (Date)	
<b>LICENSURE</b>				
State	Year	License Number (or date when exam will be taken)		

<b>EMPLOYMENT HISTORY (List most recent employer first)</b>				
Employer	Address	Dates Employed		
<b>HOSPITAL PRIVILEGES</b>				
Location	Type	Years		
Name of North Dakota dental clinic and community where you will practice		Date you will be able to begin		
<p><b><u>Check one of the following <span style="color: red;">only</span> if you are practicing in Bismarck/Mandan, Fargo, West Fargo or Grand Forks</u></b></p> <p><input type="checkbox"/> I will provide at least twenty thousand dollars of dental service to Medicaid clients per year, or</p> <p><input type="checkbox"/> I will practice at least two days per week at a public health or non-profit dental clinic that uses a sliding fee schedule to bill the clinic's patients.</p>				
I will accept Medicaid assignment in proportion to the percentage of Medicaid clients in my practice area				
<input type="checkbox"/> Yes <input type="checkbox"/> No   If no, please explain.				
Are you currently in litigation or have any actions pending?				
<input type="checkbox"/> No <input type="checkbox"/> Yes   If yes, please explain.				
Have you applied for loan repayment from other sources?				
<input type="checkbox"/> No <input type="checkbox"/> Yes   If yes, please identify.				
Are you currently receiving loan repayment from other sources?				
<input type="checkbox"/> No <input type="checkbox"/> Yes   If yes, please identify.				
<b>OUTSTANDING MEDICAL EDUCATIONAL LOANS</b>				
Lender/Address	Loan Number	Amount	Balance	Date Loan Must Be Paid
<b>PLEASE PROVIDE VERIFICATION FROM YOUR LENDER OF YOUR <u>OUTSTANDING</u> EDUCATIONAL LOANS.</b>				
Have you ever been in default on any educational loans? <input type="checkbox"/> No <input type="checkbox"/> Yes   If yes, please explain				
How much money are you requesting?				
(You may request up to a total of \$100,000 payable over a five year period)				

1. **Attach three letters of recommendation.** Letters could be from the dental clinic where you will serve, a personal reference, a community or business; if in school, a letter from a professor should be provided.
2. **Attach a copy of your North Dakota dental license.** If you do not have a license yet, attach a copy of the licensure application and send the license when it is received.
3. **Attach a paragraph** (max. of 250 words) sharing why the state of North Dakota should invest in you.

### SIGNATURES AND AFFIDAVIT

I hereby make application for a dental loan repayment award subject to the provisions of North Dakota Century Code 43-28.1 and to the rules and standards adopted by the State Health Council of the North Dakota Department of Health. I give the University of North Dakota School of Medicine and Health Sciences, on behalf of 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 and for the North Dakota Department of Health to obtain information from the University of North Dakota School of Medicine and Health Sciences to determine if any state support payments have been paid on my educational loans.

Signature of Applicant

State

County

Signed and sworn to (or affirmed) before me on

Date

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](mailto:blwill@nd.gov)