



COMMUNITY MEMORANDA OF UNDERSTANDING
 NORTH DAKOTA DEPARTMENT OF HEALTH
 HEALTH CARE PROFESSIONAL STUDENT LOAN REPAYMENT PROGRAM
 (Physicians)
 SFN 50557 (9-2015)

For Office Use Only

File Number	
Date Received	
Contract Number	HPSA Score

Name of Physician		
Name of Community (Sponsoring Organization)		Name of Community Contact Person
Name of Sponsoring Organization & Address		Is County or Facility a Federally Designated HPSA? <input type="checkbox"/> Yes <input type="checkbox"/> No
Community Contact E-mail Address:		
Specialty of Physician the Community is Seeking:		
Community Commitment Amount <i>(Provider is eligible to receive \$20,000 per year in state funds for up to five years. Community matching funds must equal 50% of the amount requested each year not to exceed the amount of educational loan totals.)</i>	Year 1	Year 2
	Year 3	Year 4
	Year 5	Total

I certify that the above named community/facility supports the above named physician and agrees to financially commit the above specified amount per year for ____ years as required in the Health Care Professional Student Loan Repayment Program, North Dakota Century Code 43-12.3

Name of Community Representative:	
Signature	Date

Return the completed form to:
 Bobbie Will, Manager
 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