



PSYCHOLOGIST LOAN REPAYMENT APPLICATION
 NORTH DAKOTA DEPARTMENT OF HEALTH
 HEALTH CARE PROFESSIONAL STUDENT LOAN REPAYMENT PROGRAM
 SFN 60944 (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 Psychologist				
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"/> Either	
Business E-mail Address				
EDUCATION AND TRAINING				
Name of School	City, State	Degree	Year of Graduation	
LICENSURE				
State	Year	License Number		

EMPLOYMENT HISTORY (List most recent employer first)				
Employer	Address	Dates Employed		
Name of North Dakota health care facility and community where you will practice				Date you will begin
Do you accept Medicare assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you accept Medicaid assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you currently in litigation or have any actions pending? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, 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.				
OUTSTANDING MEDICAL EDUCATIONAL LOANS				
Lender/Address	Loan Number	Amount	Balance	Date Loan Must Be Paid
Please provide verification from your lender of your <u>outstanding educational</u> loans.				
Have you ever been in default on any educational loan(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain.				
How much money are you requesting? You may request up to \$12,000 in state funds plus \$3,000 in community matching funds each year for up to five years; community must match 25% of the requested state funds. The total amount requested is not to exceed the amount of the outstanding educational loans.)		From State (Total Amount Requested for all years)	From Community (Total Amount Requested for all years)	

1. **Attach three letters of recommendation.** Letters could come from the facility where you will practice, a partner/colleague, someone in the community, or if in school, a letter from one of your professors.
2. **Attach a copy of your North Dakota professional license.** (If you do not have a license yet, attach a copy of the application and send the license when it is received.)
3. **Include the Community Memoranda of Understanding (SFN 60946)** signed by a community representative stating the community will pay an additional twenty-five percent of the total loan repayment amount received from the State in exchange for up to five (5) years of full-time professional services.
4. **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 student loan repayment award subject to the provisions of North Dakota Century Code 43-12.3 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; 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 University of North Dakota School of Medicine and Health Sciences to determine if any community match 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
 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