

**MEDICAL STUDENT LOAN PROGRAM  
REQUEST FOR APPROVAL OF PRACTICE IN A MEDICAL  
UNDERSERVED AREA OR IN A SPECIALTY ELIGIBLE FOR  
LOAN FORGIVENESS AND TWELVE-MONTH  
POSTPONEMENT OF LOAN PAYMENT**

NAME OF BORROWER \_\_\_\_\_

(Please print full name)

TELEPHONE \_\_\_\_\_ SS#: \_\_\_\_\_

CURRENT ADDRESS \_\_\_\_\_

I anticipate beginning practice in the field of \_\_\_\_\_  
on or about \_\_\_\_\_, 20\_\_\_\_. I will be in \_\_\_\_\_ private practice or will  
be \_\_\_\_\_ an affiliate of \_\_\_\_\_ in  
\_\_\_\_\_, West Virginia. (location  
of practice)

I understand that if this area or this specialty is an approved designated area or medical specialty physician shortage in West Virginia and if I practice full time in this area or specialty for a period of twelve (12) consecutive months, that I will be eligible to apply for loan forgiveness under the provisions of the West Virginia Board of Regents Policy Bulletin No. 63.

I hereby request approval to postpone payments on my Medical Student Loan for the twelve months following the commencement of the above described practice. I understand that if I fail to complete twelve consecutive months of practice as set forth above, this postponement will be void and I must pay all missed payments plus interest. I understand that if this request is approved, I must immediately notify \_\_\_\_\_, the medical school which granted my loan, of the actual date I commence such practice so that my payments may be postponed.

Signed \_\_\_\_\_ Date \_\_\_\_\_, 20\_\_\_\_  
(Signature of borrower)

Send form to: Medical Student Loan Program Administrator, WV Higher Education Policy Commission, 1018 Kanawha Blvd., E., Suite 700, Charleston, WV 25301

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**ACTION BY HIGHER EDUCATION POLICY COMMISSION**

\_\_\_\_\_ Request approved \_\_\_\_\_ Request disapproved

If disapproved, reason for disapproval \_\_\_\_\_

Signed \_\_\_\_\_ Date: \_\_\_\_\_, 20\_\_\_\_  
(Director of State Financial Aid Programs)

Copy of request results sent to lender on \_\_\_\_\_, 20\_\_\_\_