

# MEDICAL STUDENT LOAN PROGRAM

## CERTIFICATION OF SERVICE FOR LOAN FORGIVENESS

### General Instructions:

This form is to be used by a Medical Student Loan Program recipient to apply for loan forgiveness upon the completion of twelve (12) consecutive months of full-time clinical service in West Virginia in (1) a designated medically underserved area of West Virginia or (2) in a designated medical specialty in which there is a physician shortage in West Virginia. The applicant must have applied for and received prior approval to practice in the specialty or underserved area indicated in this certification in order to be eligible for forgiveness. Loan forgiveness is not authorized for periods of less than twelve consecutive months of practice.

Request for forgiveness should be submitted no later than 120 days after completion of service as indicated in Question 4. Send completed form, including the endorsement of (1) a medical colleague in a supervisory position such as a hospital department head, county health director, etc. and (2) a member of the community who can verify your medical practice in the area during the 12-month period indicated below, to: Administrator, Medical Student Loan Program, Higher Education Policy Commission, 1018 Kanawha Boulevard, East, Suite 700, Charleston, West Virginia 25301.

***WARNING: The giving of false information or statements on this certification of service form is a crime under the laws of the State of West Virginia. Conviction thereof shall be a misdemeanor punishable by a fine and/or imprisonment.***

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1. \_\_\_\_\_ 2. SS# \_\_\_\_\_  
(Borrower)

3. Indicate School of Medicine from which Medical Student Loan was received.  
\_\_\_\_\_

4. Loan forgiveness is requested for year of practice from \_\_\_\_\_, 20\_\_\_\_  
to \_\_\_\_\_, 20\_\_\_\_\_.

5. Forgiveness is requested for practice in (check one)  
\_\_\_\_\_ a medically underserved area or  
\_\_\_\_\_ a designated specialty.

6. In what specialty are you practicing? \_\_\_\_\_

7. Where did you maintain a full-time clinical practice during the period designated in Question 4?

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Telephone \_\_\_\_\_

8. Borrower=s Medicare Provider Number \_\_\_\_\_

9. Borrower=s Medicaid Provider Number \_\_\_\_\_

10. Please indicate the office hours you maintain during the reporting period. Please designate A.M or P.M. Use "X" for days when you were not usually practicing.

SUN. MON. TUES. WED. THURS. FRI. SAT.

From: \_\_\_\_\_

To: \_\_\_\_\_

11. Please indicate the approximate number of hours you spent each week in the treatment of hospitalized patients of the practice \_\_\_\_\_

12. \_\_\_\_\_ check here if you are requesting approval to continue to practice in this location and specialty for loan forgiveness and another twelve-month postponement of loan payments.

13. CERTIFICATION

***I certify that the above reported information is correct to the best of my knowledge and accurately reflects my activities relating to the fulfillment of my record of clinical practice in support of forgiveness of all or a portion of my indebtedness to the Medical Student Loan Program.***

\_\_\_\_\_ Date: \_\_\_\_\_

(Borrower=s signature)

\_\_\_\_\_ Telephone: \_\_\_\_\_

(Print or type borrower=s name)

Borrower=s Address \_\_\_\_\_

\_\_\_\_\_

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I, \_\_\_\_\_ a notary Public for the State of West Virginia, County of \_\_\_\_\_, do certify that \_\_\_\_\_ appeared before me this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_ and duly signed the above document.

Signed \_\_\_\_\_ My commission expires \_\_\_\_\_, 20\_\_\_\_\_

# ENDORSEMENT

I have reviewed the above information submitted by \_\_\_\_\_  
and, to the best of my knowledge, he/she did practice medicine during the reported time  
period and in the specialty and at the location indicated.

1. \_\_\_\_\_, Date: \_\_\_\_\_ 20\_\_\_\_\_  
(Signature of Health Official)  
\_\_\_\_\_, Title: \_\_\_\_\_  
(Printed name of Health Official)  
\_\_\_\_\_, Telephone: \_\_\_\_\_  
(Agency or Institution)  
Address \_\_\_\_\_

2. \_\_\_\_\_, Date: \_\_\_\_\_ 20\_\_\_\_\_  
(Signature of Member of Community)  
\_\_\_\_\_, Telephone: \_\_\_\_\_  
(Printed name)  
Address \_\_\_\_\_

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## FOR HIGHER EDUCATION POLICY COMMISSION OFFICE USE

\_\_\_\_\_ Approved forgiveness request      \_\_\_\_\_ Disapproval forgiveness request

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

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

Copy of document sent to lender on \_\_\_\_\_, 20\_\_\_\_