WEST VIRGINIA UNIVERSITY
Post-Resident Certification Form
For
PRIMARY CARE LOANS
Made after 11/13/98

BORROWERS
NAME_____
First Middle Last
STREET ADDRESS_____

CITY, STATE, ZIP_____

SOCIAL SECURITY NUMBER_____

Your Primary Care Loan promissory note stated that you agreed:

- **To enter and practice primary health care within 4 years after the date of graduation.**
- **To practice primary care until the Primary Care Loan is paid in full.**
- **That primary care is defined as family medicine, general internal medicine, general pediatrics, preventative medicine or osteopathic family medicine, internal medicine, combined medicine/pediatrics or preventative medicine**
- **To a residency training program in Primary Health care as defined as a 3 year residency program in public or osteopathic family medicine, internal medicine, combined medicine/pediatrics or preventative medicine.**
- **That Non-Compliance would result if you broke this agreement and interest would accrue at the rate of !8% from the date of non-compliance.**

Please check one of the following:

- o **This is to certify that I am and will be practicing in Primary Health Care as defined above for the next twelve months. I understand that I must inform my school of my status annually until my Primary Care Loan is paid in full.**
- o **This is to certify that I am and <u>no longer</u> practicing Primary Health Care as defined above and as required part of the Primary Care Loan Program agreement and program, effective date:**_____

Please complete the following:

Specialty_____

_____
Signature **Date**

_____

_____
Residency or Practice Address and Work Phone #

Return completed form to:

West Virginia University
Office of Student Accounts (Loans)
P.O. Box 6003
Morgantown, WV 26506-6003
304/293-2809