WEST VIRGINIA UNIVERSITY
Post-Resident Certification Form
For
PRIMARY CARE LOANS
Made after 3/23/10

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 for either 10 years (including the years spent in residency training) or through the date on which the Primary Care Loan is paid in full, whichever occurs first.
- 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 7% from the date of non-compliance.

Please check one of the following:

- ○ 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.
- ○ 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