

RETURN FORM TO:
West Virginia Higher Education Policy Commission
WV Medical Student Loan Program
1018 Kanawha Blvd., East, Suite 700
Charleston, WV 25301

WEST VIRGINIA
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 a: 1) designated medically underserved area of West Virginia; or 2) 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 a; 1) medical colleague in a supervisory position such as a hospital department head, county health director, etc., and 2) member of the community who can verify your medical practice in the area during the 12-month period indicated below to: Administrator, WV Higher Education Policy Commission, Medical Student Loan Program, 1018 Kanawha Blvd., East, Suite 700, Charleston, WV 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.



1. _____ 2. SSN _____
(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 ____ 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 maintained 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. THUR. FRI. SAT.

From: _____

To: _____

11. Please indicated 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 _____



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)

_____ Date _____, 20 ____
(Printed Name)

Address _____

FOR HIGHER EDUCATION POLICY COMMISSION OFFICE USE

_____ Approved Forgiveness Request _____ Disapproved Forgiveness Request

Signed _____ Date _____, 20 ____
(Signature of Senior Administrator)

Reason for Disapproval _____

Copy of document sent to _____,
(Lending Institution)

Date _____, 20 ____