ATTENTION

This program requires the physician to accept **Sooner Care** and **Medicare** patients. Family Medicine, Pediatric and General Internal Medicine physicians are required to register as a Medicaid Medical Home. This program is provided by a public and private partnership.

OKLAHOMA
Health Care Workforce
Training Commission

Health Care Workforce Training Commission

Physician Loan Repayment Program
Candidate Application

Loan Repayment for primary care physicians practicing in Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs) or other rural communities approved by the Health Care Workforce Training Commission

Please submit a current loan summary and a head & shoulders photo with this application.

Name _____ M.D. or D.O. SS#_____
(First, Middle, Last) (Circle one)

Medical License Number(s) _____ Specialty _____

Home Address _____
(Street/P.O. Box, City, State and Zip) (E-mail address)

Phone Number ( ) _____ Cell Phone Number ( ) _____

Business Address _____ Bus. Phone ( ) _____
(Street/P.O. Box, City, State and Zip)

Birth Date ____/____/____ Hometown _____ Marital Status _____

Spouse Name_____ Maiden Name _____ SS#_____

Spouse Occupation _____ Spouse Hometown _____

Number of Children _____ Ages _____

Applicant: Parents' Name (or Living Relative) Address and Phone _____

_____

Medical College(s), City and State Dates Attended

_____

_____

Residency Training Institution, City and State Dates Attended

_____

_____

List the community name and facility where you plan to practice: (Application is for the stated community only)

_____

Name of community sponsor and contact person: _____

_____ Projected start date: _____

Explain your community area choice:

_____

Do you presently have any scholarships/loans that have a practice obligation? _____ Yes _____ No
Participant in Federal Sponsored Loan Repayment? _____Yes _____No

If yes, please explain _____

Are you a previous HWTC Participant? _____Yes _____No

Please provide the amount owed for educational loans: _____

The Health Care Workforce Training Commission is given permission to contact any parties or to obtain the sources of information, which it deems necessary to verify my eligibility for this scholarship/loan.

The Health Care Workforce Training Commission, in compliance with Title VI of the Civil Rights Act of 1974 and Title IX of the Education Amendments of 1972 (Higher Education Act), does not discriminate on the basis of race, color, national origin or sex in any of its policies, practices, or procedures. This provision includes, but is not limited to, employment and financial services.

I hereby declare that the information contained in this application is true and correct to the best of my knowledge.

Signature of Applicant _____

Date of Application _____

Please return to:

Health Care Workforce Training Commission
119 North Robinson Avenue, Suite 520
Oklahoma City, Oklahoma 73102-4603
(405) 604-0020 FAX (405) 768-2263

10/6/2022