



Primary Care Practitioner Loan Redemption Program of New Jersey

PROVIDER APPLICATION

1. First Name	MI	Last Name	Email Address:	Place of Birth
Street Address			Telephone No.	Cell Phone No.(optional)
City	State	Zip Code	Citizenship	Second Language:
2. Specialty (please check one) <input type="checkbox"/> Family Practice <input type="checkbox"/> Obstetrics/Gynecology <input type="checkbox"/> Pediatrics <input type="checkbox"/> Internal Medicine <input type="checkbox"/> General Dentistry <input type="checkbox"/> Pediatric Dentistry <input type="checkbox"/> Certified Nurse Midwife <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner				
3. Please describe any practice experience you may have relevant to serving the needs of medically underserved. <hr/> <hr/>				

GRADUATE EDUCATION/RESIDENCY INFORMATION

4. Date Undergraduate Studies Began	Date Graduate/Professional Studies Began	Graduation Date	Degree Awarded Date
5. Graduate Program Name <hr/> <hr/>		6. Residency Program Name (if applicable) <hr/> <hr/> Residency Program Completion Date <hr/>	
Graduate Program Street Address <hr/> <hr/>		7. New Jersey Professional License # Date Issued <hr/>	
City	State	Zip Code	Board Certified <input type="checkbox"/> yes <input type="checkbox"/> no Date _____ Board Eligible <input type="checkbox"/> yes <input type="checkbox"/> no Date _____ Specialty _____ Date Scheduled to take exam _____

GRADUATE LOAN INFORMATION

Lender Name	Address	Original Loan Amount \$	Current Loan Balance (Principal/Interest)
Loan Name: (e.g. GSL, NDSL, HEAL)	Is Loan in Deferment/Forbearance <input type="checkbox"/> yes <input type="checkbox"/> no If yes, date deferment/forbearance ends		Is Loan in Default <input type="checkbox"/> yes <input type="checkbox"/> no If yes, date of default:
Lender Name	Address	Original Loan Amount \$	Current Loan Balance (Principal/Interest)
Loan Name: (e.g. GSL, NDSL, HEAL)	Is Loan in Deferment/Forbearance <input type="checkbox"/> yes <input type="checkbox"/> no If yes, date deferment/forbearance ends		Is Loan in Default <input type="checkbox"/> yes <input type="checkbox"/> no If yes, date of default:
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Lender Name	Address	Original Loan Amount \$	Current Loan Balance (Principal/Interest)
Loan Name: (e.g. GSL, NDSL, HEAL)	Is Loan in Deferment/Forbearance <input type="checkbox"/> yes <input type="checkbox"/> no If yes, date deferment/forbearance ends		Is Loan in Default <input type="checkbox"/> yes <input type="checkbox"/> no If yes, date of default:
Have you ever declared bankruptcy or defaulted on a student loan? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please indicate the name of lender, loan program and dates?			

Principal unpaid balance of ALL graduate health profession loans listed for redemption:

GRAND TOTAL\$ _____

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PLACEMENT SITE SELECTION

Please refer to the list of New Jersey Medically Underserved Index for your selection of which areas would be of interest to you:

A)	B)	C)
D)	E)	F)

8. Preferred type of practice (Please rank preference 1, 2, 3, 4): _____ Primary Care/Community Health Center _____ Group Practice _____ Private Practice _____ Hospital Based
 _____ Other, specify _____

9. If known, please give the facility or site name where you would like to practice (including contact person, address and phone)

Site Name: _____ Contact Person: _____

Address: _____ Phone: _____ Start Date: _____

Date available to begin service obligation with LRP: _____

RELEASE FROM LIABILITY/CERTIFICATION & AUTHORIZATION

I _____, hereby release from liability the Primary Care Practitioner Loan Redemption Program of New Jersey (NJLRP), and its staff, agents, and employees for acts performed in good faith without malice in connection with the evaluation of my application, credentials and qualifications, and hereby release from liability any and all individuals and organizations, who in good faith and without malice provide information to this program regarding my professional competence, ethics, character and loan information.

I certify that the information on this application is true, correct and complete to the best of my knowledge and belief and made in good faith. I certify that I am not participating in any other loan repayment program and that I am not in default on a government or commercial student loan. I understand that the NJLRP are relying on this certification.

I authorize you to obtain verification of my eligibility status and student loan debt. In addition, I agree to comply with all policies, regulations and directives of the NJLRP. I also understand that I must remain employed as a direct patient care primary care professional on a full-time basis at a qualified facility during my participation in the program in order to qualify for loan repayment.

Print Name Signature Date

SUPPORTING DOCUMENTS (Please include the following documents with the provider application)

- Copy of diploma from a graduate health professional program
- Copy of residency completion certificate (if applicable)
- Copy of specialty board certification (if applicable)
- Copy of New Jersey professional license
- Letter of recommendation from residency/ graduate health professional program director recommending participation in this loan redemption program
- Detailed loan information (Note: master promissory note; original loan dates, original loan amounts and outstanding loan balances must be indicated for all loans listed. If you have consolidated your loans for graduate education costs, you must attach a copy of the original loan documents for health profession education that were consolidated into a new loan)
- Copy of resume
- Copy of employment contract (if available)
- Copy of work schedule (if available)