PRIMARY CARE LOAN (PCL) PROGRAM
POST-RESIDENCY CERTIFICATION FORM

As a PCL recipient, you are required to practice primary health care until your loan is repaid in full. Please complete and return this form to the school that granted your Primary Care Loan.

NAME:

_____

HOME ADDRESS:

_____

_____

PHONE NUMBERS:

(____) _____ (WORK)

(____) _____ (HOME)

WORK ADDRESS:

_____

_____

CURRENT PRACTICE STATUS:

_____ FAMILY MEDICINE

_____ GENERAL PEDIATRICS

_____ OSTEOPATHIC GENERAL PRACTICE

_____ GENERAL INTERNAL MEDICINE

_____ PREVENTIVE MEDICINE

_____ GENERAL DENTISTRY

COMMENTS: _____

_____

_____

I CERTIFY THAT THE INFORMATION CONTAINED ON THIS CERTIFICATION FORM IS ACCURATE AND THAT I AM IN COMPLIANCE WITH THE OBLIGATIONS SPECIFIED IN MY PRIMARY CARE LOAN PROMISSORY NOTE FOR PRIMARY HEALTH CARE SERVICE.

_____ _____

SIGNATURE DATE

RETURN COMPLETED FORM TO THE SCHOOL THAT GRANTED YOUR PRIMARY CARE LOAN.