

SAMPLE

EXCEPTIONAL FINANCIAL NEED (EFN), FINANCIAL ASSISTANCE FOR
DISADVANTAGED HEALTH PROFESSIONS STUDENTS (FADHPS)
AND PRIMARY CARE LOAN (PCL) PROGRAMS
POST-RESIDENCY CERTIFICATION FORM

As an EFN and FADHPS recipient you are required to practice primary health care for 5 years after completion of residency.
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
us in the enclosed envelope.

NAME

HOME ADDRESS

PHONE NUMBERS

() _____ (WORK)
() _____ (HOME)

WORK ADDRESS

CURRENT PRACTICE STATUS:

FAMILY MEDICINE

GENERAL INTERNAL MEDICINE

GENERAL PEDIATRICS

PREVENTIVE MEDICINE

OSTEOPATHIC GENERAL PRACTICE

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 EFN/FADHPS AGREEMENT(S) AND/OR PRIMARY CARE LOAN
PROMISSORY NOTE FOR PRIMARY HEALTH CARE SERVICE.

SIGNATURE

DATE

RETURN COMPLETED FORM TO: