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 ____

EMAIL: __________________________

HOME ADDRESS

____

____

PHONE NUMBERS

(____)____________________**(HOME)**

(____)____________________**(WORK)**

WORK ADDRESS

____

____

____

CURRENT PRACTICE STATUS:

_____ GENERAL INTERNAL MEDICINE

_____ GENERAL PEDIATRICS

_____ OSTEOPATHIC GENERAL PRACTICE

_____ FAMILY MEDICINE

_____ PREVENTIVE MEDICINE

_____ GENERAL DENTISTRY

COMMENTS: ____

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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:

OFFICE OF STUDENT AFFAIRS
SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE
P.O. BOX 19624
SPRINGFIELD, IL 62794-9624