APPLICATION PART B

DELAWARE STATE LOAN REPAYMENT PROGRAM

HEALTH PROFESSIONAL (Practitioner) APPLICATION FORM

☐ **New Applicant** ☐ **Continuing Application Request** ☐ **Previous Application Not Awarded**

☐ **SLRP** ☐ **Other**

1. **Full Name**: _____ **Date of Application**: _____

2. **Date of Birth**: _____ **Place of Birth**:

3. **US Citizen**: ☐ Yes ☐ No

For purposes of this Program and the required application requirements, proof of United States citizenship or permanent legal resident of the United States must be established by providing with this application a certified color copy of one of the following documents: birth certificate, naturalization papers, United States passport, or marriage certificate (for legal permanent residents). For selected refugees, a certified copy of the approval by the United States Attorney General shall be required.

4. **Present Home Address**: **Residency** ☐ 0-2 Years
☐ 2-4 Years
☐ 4+ Years

Home Telephone: **Cell Phone**: _____
Email Address: _____

5. **Name of Practice Site**: **Start Date**:_____
Address of Site:
Salary: _____

6. **Discipline**: Indicate the specialty you are interested in practicing and, if applicable, subspecialties and percent of time devoted to each.

	Discipline	**Specialty** (Geriatric, peds, etc.)
☐	Allopathic Medicine (MD)	
☐	Osteopathic Medicine (DO)	
☐	General and Pediatric Dentistry (DDS/DMD)	
☐	Nurse Practitioner (NP)	
☐	Certified Nurse Midwife (CNM)	
☐	Physician Assistant (PA)	
☐	Registered Dental Hygienist (RDH)	
☐	Health Service Psychologist (HSP)	
☐	Licensed Clinical Social Worker (LCSW)	
☐	Psychiatric Nurse Specialist (PSN)	
☐	Licensed Professional Counselor (LPC)	
☐	Licensed Alcohol/Drug Counselor (LADC)	
☐	Marriage and Family Therapist (MFT)	
☐	Registered Nurse (RN)	
☐	Pharmacist (PharmD)	

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8. **Professional License**:
   Type: _____
   State: _____ Number:
   Date Issued: _____ Expires:
   Restrictions: _____

National Provider Identification (NPI): _____

Attach a full self-query from the National Practitioner Data Bank (NPDB). The NPDB is an information clearinghouse created by Congress with the primary goals of improving health care quality, protecting the public, and reducing health care fraud and abuse in the United States. NPDB information is intended to be used in combination with information from other sources when entities are making decisions regarding licensure, employment, contracting, membership or clinical privileges, or when conducting investigations. ☐ Yes ☐ No

9. **Has your license ever been suspended or revoked?** ☐ Yes ☐ No

10. **Are there any disciplinary actions pending?** ☐ Yes ☐ No

11. **Have you ever been convicted of or pled guilty to a felony as so defined under either Federal or State law and as more particularly enumerated in 11 Del.C.Sec.4201?** ☐ Yes ☐ No

12. ***If you answered yes to any of the above questions, please explain:***

13. **Are you Dental/Medical Board Eligible**? ☐ **Yes** ☐ **No**
14. **Are you Dental/Medical Board Certified?** ☐ **Yes** ☐ **No**

Date of Certification:
Name of Board:
Sub-Specialty Board:

15. **Education**: *(Please use additional paper if necessary)*

Delaware Institute for Dental Education and Research Graduate ☐ **Honors** ☐ **Recommendation** ☐ **No**
Delaware Institute for Medical Education and Research Graduate ☐ **Honors** ☐ **Recommendation** ☐ **No**

College/Program: _
Address: _

From: _____ To: _____
Degree/Diploma: Discipline:
College Contact Person: _____
Telephone: _____

16. **Graduate School:**
Address:
From: _____ To: _____
Degree/Diploma: Discipline:
Graduate School Contact Person:
Telephone:

17. **Medical /Dental School:**
Address:
From: _____ To: _____
Degree/Diploma: Discipline:
Medical/Dental School Contact Person:
Telephone:

18. **Please list the information for the residency program most recently completed. If you have completed several residencies, or if your postgraduate training was completed through several programs, attach the required information for these programs to the application.**

Residency Program:
Address:

From: _____ To: _____
Degree/Diploma: Discipline:
Residency Program Contact Person:
Telephone:

19. **Please indicate if your education, employment, or licensure records are under any other name(s):**

_____
Other Name(s)

20. **Program Eligibility** *(Please use additional paper or submit at end of form, if needed)*:

Have you secured matching funds (50%) through the State of Delaware or with the practice site?

☐ **Yes** ☐ **No**

If no, *please refer to the program guidelines for additional information. This requirement must be coordinated with, and approved by, your employer (practice site) before execution of contracts.*

21. **Do you have a current or outstanding obligation to provide health professional services with any federal, state, or other entity**?
☐ **Yes** ☐ **No**

If yes, *please provide the following information*:

Program Name:
Address:
Program Contact Person: ___
Telephone: ___

When will this obligation be complete?

22. **Do you have a current legal obligation to pay child support**? ☐ **Yes** ☐ **No**
If yes, are your child support payments up to date? ☐ **Yes** ☐ **No**

Name of Child(ren), if applicable: _____

Name and Address of person/agency payment is mailed to:
Telephone: _____

When will child support obligation(s) be complete? _____

23. **Language(s) Medically Fluently**:

☐	English (Mandatory)	☐	French
☐	Spanish	☐	German
☐	Arabic	☐	Chinese
☐	Indian	☐	Other: *(Please specify)* _____

24. **Race/Ethnicity** *(collected for workforce research purposes only)*:

☐	African American	☐	Asian
☐	Hispanic	☐	American Indian, Alaskan Native
☐	Caucasian	☐	Pacific Islander, Native Hawaiian
		☐	Other: *(Please specify)*

25. **Affiliated with Delaware Health Information Network (DHIN):** ☐ **Yes** ☐ **No**

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26. Geographical Area(s) or Origin:
Are you a native of a rural area, or have you spent a significant amount of time living or working in such an area?

☐ **Yes** ☐ **No**

If yes, *please elaborate*: _____

27. Are you a current, or previous, Delaware resident practicing in the State?

☐ **Yes** ☐ **No**

If yes, *please explain relationship to the community you will be serving*. __

28. What date are you available for service? _____

29. How did you hear about the Delaware State Loan Repayment Program?

30. Describe your education and practice experience, which you believe qualifies you to participate in the Delaware State Loan Repayment Program *(enter in the text field below)*:

- Training, experience and commitment to providing services to underserved and vulnerable populations.
- Practice experience in professional shortage areas.
- Personal origins or other factors that describe your commitment to practice in a shortage area and/or to serve vulnerable populations.
- Service awards received during your education or practice.
- Pre-professional experiences which caused you to decide to practice in a shortage area: and Physicians and dentists should discuss their collaborative practice experience and commitment to working with physician assistants, certified registered nurse practitioners, dental hygienists, and other practitioner disciplines.

Type Answer to #30 Here or Submit on a Separate Sheet of Paper

31. If you need to clarify or elaborate on any answers you provided on this form, please do so in the space provided here or provide on separate sheet of paper: _____

Certification:

I certify that the information provided in this application packet is accurate and complete to the best of my knowledge. I hereby authorize Delaware Health Care Commission to contact references and program directors listed in the application for the purpose of obtaining information about my professional qualifications, experience, abilities, and criminal history background. I understand that information I have provided is subject to verification, serves the same purpose as a legal signature, and is binding.

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- I certify, as required in the application, that I have read and understand all application instructions, including the provisions which note that I am responsible for monitoring and ensuring the progress of my application.
- I certify that I have read and will abide by all program-specific instructions for my designated physical therapist programs.
- I certify that all the information and statements I have provided in this application are current, correct, and complete to the best of my knowledge.
- I certify that my personal essay and the information on my application represent my own work.
- I understand that withholding information requested on the SLRP application, or giving false information, may be grounds for denial of the application and further award consideration.
- I agree, understand and consent to information collected in this application, and future surveys associated with this program, will be used for statistical purposes; such as educational research used to improve the program guidelines.
- I acknowledge and agree that my sole remedy in the event of any proven errors or omissions related to the handling or processing of my application by Delaware Health Care Commission is to submit written notice to DHCC@state.de.us within fifteen (15) days of the event.
- *I agree not to submit more than one (1) completed application during the application cycle, and acknowledge that any duplicate applications I create or submit may be disregarded by Delaware Health Care Commission.*

_____ _____

Signature of SLRP Applicant Date

Submit only one (1) copy of the application:

Department of Health and Social Services
Delaware Health Care Commission
Herman M. Holloway Sr. Campus
1901 North DuPont Highway – H117
Main Administrative Building – 1st Floor
New Castle, Delaware 19720
Fax (302) 255 - 4751 | Email DHCC@delaware.gov (security needed)

RESOURCE MATERIAL

Application Checklist: This checklist was developed to help you submit a complete application in one attempt. *Please ensure the following documents are included in your application package on or before the application due date:*

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- ☐ Application Includes Parts A and C
  - ☐ Being sent separately from organization/company ***with*** authorized signatures
- ☐ Application, Part B (must have applicant signature and all sections completed)
- ☐ Proof of Citizenship/Driver's License (**color** photocopy)
- ☐ Most current executed contract with Employer (Practice Site)
- ☐ Self-Query from the federal National Practitioner Data Bank - NPDB
- ☐ Copy of Health Professional License (State of Delaware)
- ☐ Copy of Highest Degree/Certification Obtained (**color** photocopy)
- ☐ Curriculum Vitae (CV) or Resume
- ☐ Narrative response to Question # 30
- ☐ Completed W-9 (Request for Taxpayer Identification Number and Certification): https://www.irs.gov/pub/irs-pdf/fw9.pdf (See Application B, Attachment 1)

If above documents are not included in this application submission, please explain: _____