|  |  |  |
| --- | --- | --- |
| 1. | Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2. | Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Place of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. 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 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.*
2. Present Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| 5. | Home Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

1. Name of Practice Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Employment Start Date at Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |  |  |
| --- | --- | --- |
|  |  | Specialty |
|  | 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) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Marriage and Family Therapist (MFT) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| 8. | License: |  |
|  | Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Date Issued: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

Has your license ever been suspended or revoked?  Yes  No  
  
Are there any disciplinary actions pending?  Yes  No  
  
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](http://delcode.delaware.gov/title11/c042/index.shtml)\*  
  Yes  No   
*\*If you answered yes to any of the above questions, please explain:* Type Explanation Here or Submit on Separate Sheet of Paper

1. Are you Board Eligible?  Yes  No   
     
   Are you Board Certified?  Yes  No   
     
   Date of Certification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   Name of Board: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   Sub-Specialty Board: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Education: (Please use additional paper if necessary)  
   **College/Program:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
|  | From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Degree/Diploma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Discipline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Graduate School:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
|  | From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Degree/Diploma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Discipline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Medical /Dental School:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
   **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Degree/Diploma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Discipline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please indicate if your education, employment, or licensure records are under any other name(s):   
     
   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
   Other Name(s)
2. 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.

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
When will this obligation be complete? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
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 obligation be complete? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Language(s) spoken Fluently:

|  |  |  |  |
| --- | --- | --- | --- |
|  | English |  | French |
|  | Spanish |  | German |
|  | Arabic |  | Chinese |
|  | Indian |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | African American |  | Asian |
|  | Hispanic |  | American Indian, Alaskan Native |
|  | Caucasian |  | Pacific Islander, Native Hawaiian |
|  |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. 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: yyy

1. Are you a current or previous Delaware resident returning here to practice?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes |  | No |

If yes, please explain relationship to the community you will be serving. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What date are you available for service? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How did you hear about the Delaware State Loan Repayment Program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. 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 and experience and commitment to providing services to underserved and vulnerable populations.
   * Practice experience in 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 Answers to #22 Here or Submit on Separate Sheet of Paper\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Certification:   
   I certify that the information provided in this application packet is accurate and complete to the best of my knowledge. I hereby authorize DHCC 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.

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature of Loan Repayment Applicant | Date |

**Checklist**: Please ensure the following are included in your application package:

|  |  |
| --- | --- |
|  | Application, Part A – OR –  Being sent separately from Facility |
|  | Application, Parts B & C |
|  | Proof of Citizenship (photocopy) |
|  | Copy of Health Professional License |
|  | Curriculum Vitae (CV) or Resume |
|  | Answers to Questions # 22 |

If above documents are not included, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_