IMPORTANT

While medical providers in eligible disciplines may apply for more than one Loan Repayment Program at a time, if offered an award by more than one program, only one award may be accepted. Once a Loan Repayment program contract is in place, awardees are unable to switch programs, and must complete their service obligation before applying to other Loan Repayment programs. Examples of Loan Repayment programs include, but are not limited to, Oregon Partnership State Loan Repayment Program (SLRP), National Health Service Corps (NHSC), Oregon Health Care Provider Loan Repayment, NURSE Corps, NHSC Scholars, and/or other State, Federal, or local Loan Repayment Programs offering funds in exchange for a service obligation.

OREGON PARTNERSHIP STATE LOAN REPAYMENT PROGRAM (SLRP) CANDIDATE APPLICATION

Instructions for completing and submitting the SLRP application

Please use the provided fillable PDF, handwritten applications will not be accepted

The following documents **are required** for an application packet to be considered complete:

- Completed 2023/2024 Candidate Application (hand written applications will not be accepted);
- Personal Statements (Application Part D);
- Educational Debt Reporting Form **and** copies of current lender statements dated within one month of application submission (Application Part E);
- Two letters of recommendation (Application Part F);
- Service site information form completed by site contact (page 5 of application);
- Copy of current license or certification;
- Current CV;
- Copy of signed employment contract or offer letter.

Scan and email complete application package to:
ruralworkforce@ohsu.edu fax to: 503-494-4798

Please contact the Office of Rural Health's SLRP Coordinator if you have any questions regarding this application or your site's eligibility:
ruralworkforce@ohsu.edu | 503-494-4450 | toll free: 866-674-4376

PART A: PERSONAL DATA

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

Social Security Number: _____ Birth Date: _____

Please indicate your National Provider Identifier (NPI):_____

Hometown (City & State):_____

How do you identify your race, ethnicity, tribal affiliation, or ancestry?_____

How do you identify your gender?_____

Were you raised in a rural community? Yes ☐ No ☐

Are you from a disadvantaged background? Yes ☐ No ☐

Are you a veteran? Yes ☐ No ☐

Do you hold a DATA 2000 Waiver? Yes ☐ No ☐ If "Yes" at what level (e.g. DW100)_____

Do you hold a Substance Use Disorder license or certification? Yes ☐ No ☐

Do you provide Medication Assisted Treatment (MAT)? Yes ☐ No ☐

PART B: QUALIFICATIONS AND ELIGIBLITY

1. Are you a United States citizen? Yes ☐ No ☐
   Applicants must be a US citizen at time of application submission.
2. Do you have a current and unrestricted Oregon license to practice your profession? Yes ☐ No ☐
   Applicants must have a current unrestricted license at time of application submission.
3. Do you owe an existing service obligation to another entity? Yes ☐ No ☐
   (If yes, please provide explanation in your personal statements, Part D of this application)
4. Are you free of judgments arising from Federal debt? Yes ☐ No ☐
   (If no, please provide explanation in your personal statements, Part D of this application)
5. Are you delinquent with any court ordered child support? Yes ☐ No ☐
   (If yes, please provide explanation in your personal statements, Part D of this application)
6. Are you an NHSC Scholar or Alumni? Yes ☐ No ☐
   (If yes, please provide the date that your NHSC service obligation was completed: _____)
7. Did you apply for the NHSC Federal Loan Repayment Program? Yes ☐ No ☐
   (*If yes, please indicate the date of submission and result: _____)*

PART C: HEALTH PROFESSION INFORMATION

Please indicate your primary care profession from the list below:

- ☐ MD: Doctor of Allopathic Medicine
- ☐ DO: Doctor of Osteopathic Medicine
- ☐ DD: General Practice Dentist (D.D.S. or D.M.D.)
- ☐ PD: Pediatric Dentist
- ☐ NP: Primary Care Certified Nurse Practitioner
- ☐ NM: Certified Nurse-Midwife
- ☐ PA: Primary Care Physician Assistant
- ☐ EPDH: Expanded Practice Dental Hygienists
- ☐ CADC: Certified Alcohol and Drug Counselor III
- ☐ CSW: Licensed Clinical Social Worker (master's or doctoral)
- ☐ LMHC: Licensed Mental Health Counselor
- ☐ LPC: Licensed Professional Counselor (master's or doctoral)
- ☐ MFT: Marriage and Family Therapist (master's or doctoral)
- ☐ RN: Registered Nurse
- ☐ PharmD: Pharmacist
- ☐ PNS: Psychiatric Nurse Specialist
- ☐ HSP: Health Service Psychologist (Ph.D.)

Please list Specialty: _____

School: _____

Degree: _____

Dates attended: _____

City: _____

State: _____ Zip: _____

Residency Program: _____

City: _____ State: _____

Dates attended: _____

Additional Postgraduate Training: _____

Dates attended: _____

Have you ever participated in Area Health Education Center (AHEC) programs? Yes ☐ No ☐

Board Eligible: Yes ☐ No ☐ Board Certified: Yes ☐ No ☐

Professional License Number: _____ Certificate Number: _____

PART D: PERSONAL STATEMENTS:

Attach your personal statements to this application. Your statements must be typed and no more than one-page in total length. Restate and number each question along with your answer.

1. Describe the types of training or work experience you have had in a medical, dental, or mental Health Professional Shortage Area.
2. Describe the patient population to which you provide/will provide services, including any health disparities experienced by that population; **AND** describe how you, as a health care provider, will address these disparities and/or increase the health outcomes of that patient population (e.g., community outreach/education, support groups, and/or research)
3. Why you wish to participate in the Oregon Partnership State Loan Repayment Program.
4. If applicable, provide detailed explanations for questions answered in Part B of this application.

PART E: EDUCATIONAL DEBT REPORTING

All spaces on this form must be completed even if the information appears on your lender statements. Any missing information will make the entire application incomplete and the application will not be reviewed.

Current lender statements must be dated within 30 days of submission and MUST include the current balance, account number, your name, the loan's date of origination and/or school name, and the address to which payment is submitted for each loan reported. Online printouts are acceptable as long as they include all of the required information.

You must submit evidence of the educational debts listed below. **If your loans have been consolidated you must submit detailed documentation on the consolidation** (Please see our FAQs).

Only submit proof of debt for those loans obtained during the course of your graduate education (except for EPDHs) which led to your current license/certification as a qualified provider for this program.

The preferred file type when submitting all documentation related to your application is .PDF. ORH is able to accept .JPEG, .TIFF, or .PNG, files so long as they are attached to an email rather than imbedded. Files embedded in emails are blocked by ORH's email firewall. **ORH is unable to accept files that can be altered (e.g. .doc & .TXT files), even if they are converted to a different file type before they are submitted** (please see our FAQs).

1. Lender Name: _____
   Lender Address (send payments to):_____
   City: _____ State: _____ Zip +4: _____
   Account Number: _____ Current Loan Balance $_____
   Dates debt was incurred:_____

2. Lender Name: _____
   Lender Address (send payments to):_____
   City: _____ State: _____ Zip +4: _____
   Account Number: _____ Current Loan Balance $ _____
   Dates debt was incurred:_____

3. Lender Name: _____
   Lender Address (send payments to):_____
   City: _____ State: _____ Zip +4: _____
   Account Number: _____ Current Loan Balance $ _____
   Dates debt was incurred:_____

4. Lender Name: _____
   Lender Address (send payments to):_____
   City: _____ State: _____ Zip +4: _____
   Account Number: _____ Current Loan Balance $ _____
   Dates debt was incurred:_____

PART F: REFERENCES

Please include letters of reference from at least **two** individuals, including your service site (at which you will be serving your obligation if awarded) demonstrating your suitability for participation in the Oregon Partnership State Loan Repayment Program. If you are a recent graduate, or in a residency program, you may include one reference letter from the Director of your training program.

Reference letters must be typed on letterhead and include the following:

- A statement of the writer's relationship to you; and
- The length of time the writer has known you in a professional capacity; and
- An evaluation of your suitability for participation in this program; and
- The writer's typed or printed name and telephone number

Materials sent independently from your SLRP application will not be accepted. Please attach your letters of reference to your completed SLPR application packet.

PART G: QUESTIONNAIRE (optional)

Where did you hear about the Oregon Partnership State Loan Repayment Program?

APPLICATION CERTIFICATION

I certify that the information I've supplied in this application and attachments is accurate and complete to the best of my knowledge. I hereby authorize the Oregon Office of Rural Health to contact references, employers, and program directors listed in the application for the purpose of obtaining information about my professional qualifications and experience. I understand that the information I have provided is subject to verification, and providing willfully false information will result in disqualification from participation in this program.

Signature:_____ Date:_____

Printed Name:_____

Oregon Office of Rural Health
Oregon Partnership State Loan Repayment Program (SLRP)

Service Site Information & Attestation

Re: SLRP confirmation of Employment & Site Attestation

Oregon Office of Rural Health
3030 S Moody Ave | Ste 200
Portland OR 97201

This letter is to confirm employment for the following SLRP applicant listed below:

Provider's Name: _____

Site Name: _____

Site Address: _____

Provider's Employment Start Date: _____

Provider's FTE Status: Full-Time ☐ Part-Time ☐

Number of provider's weekly direct patient care hours:

Site Contact Information:

Site Contact: _____

Site Contact Title: _____

Site Contact Email: _____

Site Contact Direct phone Number: _____

SLRP Site Approval Confirmed: Yes ☐ No ☐

Site Attestation:

I confirm the following as the applicant's service site:

- Our site supports our provider's application for the SLRP; and
- I have confirmed with the Oregon Office of Rural Health that our site qualifies for the SLRP; and
- Our site will comply with all SLRP verifications during the life of our provider's award.

Signature:_____ Date_____

Printed Name & Title:_____