

Pennington Rural Health Services Loan Repayment Program Application

ALLIED HEALTH

GOVERNOR’S Office of Science, Innovation, and Technology 100 North Stewart Street, Ste 220

Carson City, Nevada 89701

(775) 687-0987

\**Please return completed applications as a single PDF to Brian Mitchell: blmitchell@gov.nv.gov*

**PERSONAL DATA** *(If additional space is needed, attach separate sheet to this form)*

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| --- | --- |
| Name (first, middle, last): | Click or tap here to enter text. |
| Date of Birth: | Click or tap here to enter text. | Place of birth: | Click or tap here to enter text.  |  Male [ ]  Female [ ]  |
| Professional Address: | Click or tap here to enter text. | City, State, Zip | Click or tap here to enter text. |
| Home Address: | Click or tap here to enter text. | City, State, Zip | Click or tap here to enter text. |
| Office Phone: Click or tap here to enter text. | Home Phone: Click or tap here to enter text. | Email: Click or tap here to enter text. |
| Where do you prefer to be contacted? | Office [ ]  Home: [ ]  |
| Race/Ethnicity: | American Indian or Alaska Native [ ]  Asian [ ]  Black or African American [ ]  Hispanic or Latino [ ]  Native Hawaiian [ ]  Other Pacific Islander [ ]  Caucasian [ ]  |
| United States Citizen: | Yes [ ]  No [ ]  |

**EDUCATIONAL STATUS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Education | Name of Institution/Program | City & State | Dates attended | Degree Granted |
| Undergraduate | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Graduate | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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**PROFESSIONAL STATUS**

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| **DISCIPLINE:** | Click or tap here to enter text. | TEACHING APPOINTMENTS |
| LICENSURE | *Institution, City & State* | *Date(s)* | *Full-time Part-time* |
| *State:* | Click or tap here to enter text. | 1. Click or tap here to enter text. | Click or tap here to enter text. | FT [ ]  PT [ ]  |
| *Date:* | Click or tap to enter a date. | 2. Click or tap here to enter text. | Click or tap here to enter text. | FT [ ]  PT [ ]  |
| *License no.:* | Click or tap here to enter text. | 3. Click or tap here to enter text. | Click or tap here to enter text. | FT [ ]  PT [ ]  |
| CERTIFICATION | 4. Click or tap here to enter text. | Click or tap here to enter text. | FT [ ]  PT [ ]  |
| *Specialty:* | Click or tap here to enter text. | 5. Click or tap here to enter text. | Click or tap here to enter text. | FT [ ]  PT [ ]  |
| *State* | Click or tap here to enter text. | 6. Click or tap here to enter text. | Click or tap here to enter text. | FT [ ]  PT [ ]  |
| *Date:* | Click or tap to enter a date. | 7. Click or tap here to enter text. | Click or tap here to enter text. | FT [ ]  PT [ ]  |

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| Do you have specific training and credentials to provide evidence-based SUD (Substance Use Disorder) treatment & counseling? |
| NO [ ]  YES-Counseling [ ]  YES-Buprenorphine [ ]  YES- BOTH [ ]  |
| Do you have a SUD License certificate issued by the State or a national credentialing organization? YES [ ]  NO [ ]  |
| Do you possess a DATA 2000 waiver? NO [ ]  DW30 [ ]  DW100 [ ]  DW275 [ ]  |
| Are you engaged in telehealth? NO [ ]  YES [ ]  If YES, percentage of time (0 to 100%): | Click or tap here to enter text. |
| MEMBERSHIPS:  | Click or tap here to enter text. |
|  | Click or tap here to enter text. |
|  | Click or tap here to enter text. |
|  | Click or tap here to enter text. |
|  | Click or tap here to enter text. |

**NEVADA EMPLOYER**

|  |  |  |  |
| --- | --- | --- | --- |
| Nevada Employer: | Click or tap here to enter text. | Start Date (Expected): | Click or tap to enter a date. |
| Address: | Click or tap here to enter text. | City, State, Zip: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. | Fax: | Click or tap here to enter text. |
| Administrative contact: | Click or tap here to enter text. | Email: | Click or tap here to enter text. |
| TYPE OF ORGANIZATION:  |
|  [ ]  Private Non-profit [ ]  Public non-profit [ ]  Private [ ]  Community health Center [ ]  Certified Rural health Clinic [ ]  Group practice [ ]  Private practice |
| List expected clinical hours spent with patients per week: | Click or tap here to enter text. |

**PROFESSIONAL EXPERIENCE**

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| --- |
| PRACTICE HISTORY |
| From: | To: | Position: | Address: |
| Click or tap to enter a date. | Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap to enter a date. | Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap to enter a date. | Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap to enter a date. | Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap to enter a date. | Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap to enter a date. | Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. |
| Other practice history: Click or tap here to enter text. |

 *If you answer “yes” to any of these questions, please explain fully on separate sheet*

|  |  |
| --- | --- |
| 1) Have you ever had your practice license revoked, suspended, or limited? | YES [ ]  NO [ ]  |
| 2) Have you ever been investigated for, charged with, or convicted of unprofessional conduct, professional incompetence, or gross or repeated malpractice? | YES [ ]  NO [ ]  |
| 3) Have you applied for any other state, federal or local government funds: Choose an item.  *If other, please specify: Click or tap here to enter text.*  | YES [ ]  NO [ ]  |
| 4) Have you been granted any other state, federal or local government funds? | YES [ ]  NO [ ]  |
| Type: | Click or tap here to enter text. | Amount: | $ Click or tap here to enter text. |

**REFERENCES** *(Please list 3 professional references)*

|  |  |
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| Name: | Click or tap here to enter text. |
| School: | Click or tap here to enter text. |
| Address: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. |

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| --- | --- |
| Name: | Click or tap here to enter text. |
| School: | Click or tap here to enter text. |
| Address: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. |

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| Name: | Click or tap here to enter text. |
| School: | Click or tap here to enter text. |
| Address: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. |

**LOAN INFORMATION**

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| For all loans considered for repayment under this program, original loan documentation must be attached to this application. Acceptable documentation is the ‘Promissory Note’ and the ‘Notice of Loan Guarantee and Disclosure Statement’ for each loan.  |
| Proof of current loan balances also need to be attached. Statements of balances can be obtained through the National Student Loan Data System – <https://nslds.ed.gov> for federal student loans. |
| **CONSOLIDATED or REFINANCED Loans**: if an eligible educational loan is consolidated and/or refinanced with any debt other than eligible educational loans, the entire consolidated/refinanced loan is not eligible for this program*.* Original loan documentation must be attached for *each loan* contained in a consolidated or refinanced loan to verify eligibility.  |
| **Name:** | Click or tap here to enter text. |
|  |  *First Middle Initial Last* |
| **Address:** | Click or tap here to enter text. |
|  |  *Street No. Street Name Apt #/ Ste* |
|  | Click or tap here to enter text. |
|  |  *City State Zip Code* |

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| Name the lending institution or Federal or State Program: Click or tap here to enter text. |
| Date of Loan: | Click or tap to enter a date. |  Loan No.: | Click or tap here to enter text. |
| Original amount of Loan: | $ Click or tap here to enter text. | Interest Rate: | Click or tap here to enter text. |
| Current Balance: | $ Click or tap here to enter text. | Date of Balance: | Click or tap to enter a date. |
| Payment Amount: | $ Click or tap here to enter text. | Total of Payments Made: | $ Click or tap here to enter text. |
| Purpose of Loan as indicated on the Loan Application: Click or tap here to enter text. |

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| Current Balance: | $ Click or tap here to enter text. | Date of Balance: | Click or tap to enter a date. |
| Payment Amount: | $ Click or tap here to enter text. | Total of Payments Made: | $ Click or tap here to enter text. |
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| Current Balance: | $ Click or tap here to enter text. | Date of Balance: | Click or tap to enter a date. |
| Payment Amount: | $ Click or tap here to enter text. | Total of Payments Made: | $ Click or tap here to enter text. |
| Purpose of Loan as indicated on the Loan Application: Click or tap here to enter text. |



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I hereby give the Governor's Office of Science, Innovation and Technology permission to contact my references, to verify any, and all information on this application, and to receive any information regarding my employment status from my employer. I certify that all information provided in this application is true and accurate, to the best of my knowledge; that I have reviewed and agree to the terms and conditions contained in the *Loan Repayment Policy Guidance Document;* that I meet the eligibility requirements of the program; that I agree to fulfill my practice obligation in full if selected for funding; and that I agree to comply with all other requirements of PRHSLRP. Additionally, I certify that I have no other outstanding contractual obligation for health professional service to the Federal Government or another state or entity; that I am not delinquent in child support payments; that I do not have a judgment lien against my property for a debt to the United States; that I have not defaulted on any Federal payment obligations; that I have not breached a prior service obligation to the Federal, or State, or local government or other entities; and that I have not had any Federal debt written off as uncollectible or had any Federal service or payment obligation waived. I understand that failure to certify the above conditions of application, by my signature below, will render this application invalid.

 Signature

 Date: Click or tap to enter a date.



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**EMPLOYER ENDORSEMENT**

I endorse the application of Click or tap here to enter text. (Candidate) for the Pennington Rural Health Services Loan Repayment Program (PRHSLRP), administered by the Governor’s Office of Science, Innovation and Technology (OSIT). I certify that the Candidate is currently employed or will start on the following date Click or tap to enter a date. and will work full time. I certify that the Site will allow for the Candidate to provide full time primary care services to all patients regardless of their ability to pay and to accept Medicaid, Nevada Check Up and Medicare on assignment. I agree to notify OSIT in the event there is a change in employment status of the Candidate.

|  |  |
| --- | --- |
| Employer Name (Site) | Click or tap here to enter text. |
| Physical Address | Click or tap here to enter text. |
| Phone | Click or tap here to enter text. |
| Email | Click or tap here to enter text. |
| Signature |  |
| Printed Name | Click or tap here to enter text. |
| Title | Click or tap here to enter text. |
| Date | Click or tap to enter a date. |