



KANSAS STATE LOAN REPAYMENT PROGRAM

Health Care Professional Application for Contract Continuation

For more information: <http://www.kdheks.gov/olrh/FundLoan.html>
Email questions to: kdhe.primarycare@ks.gov

Health Care Professional Name: _____ Discipline: _____

Health Care Practice Site: _____

This application is to be completed by **current** State Loan Repayment Program (SLRP) participants who will be completing the initial SLRP contract this year and wish to continue in the program for another year. There have been changes to the SLRP, please read the *Overview and Application Guidance* and *Frequently Asked Questions* documents in their entirety before completing this application or submitting questions regarding the SLRP. The application and attachments must be complete, typed or printed legibly, and submitted between June 1 and July 31 of the application year. No early or late applications will be accepted. No incomplete applications will be accepted.

HEALTH CARE PROFESSIONAL PERSONAL INFORMATION

Home Street Address: _____

City: _____ KS Zip: _____ + _____

Phone: _____ Email: _____

HEALTH CARE PROFESSIONAL LOAN INFORMATION

Complete the following information for each outstanding educational loan received to support undergraduate or graduate education that led to the completion of your current professional training and licensure. If any eligible loan is consolidated or refinanced with a non-educational loan, no portion of the consolidated/refinanced loan is eligible for loan repayment.

Complete the following table for each loan marked LOAN 1, LOAN 2, LOAN 3, etc., Add as many loan summary pages as needed with your name and practice site name on the top of each additional page. The following documentation must be included for each eligible loan to be considered for the SLRP.

- current account statement dated within 30 days of SLRP application; and
- statement from the current loan holder indicating:
 - borrower's name;
 - original amount borrowed;
 - current loan balance;
 - date of disbursement; and
 - type of loan.

Loan Summary Table

LOAN #	ACCOUNT #	ACADEMIC PERIOD	ORIGINAL AMOUNT	ORIGINAL DATE	CURRENT BALANCE	CURRENT BALANCE DATE
Loan 1						
Loan 2						
Loan 3						
Loan 4						
Loan 5						
Loan 6						
Loan 7						
Loan 8						
TOTAL						

LOAN 1 (as listed on original SLRP application)

Lending institution name: _____

Loan account no.: _____ Type of loan (e.g., GSL, NDSL, HEAL): _____

Original Loan Amount: _____ Current loan balance: _____

LOAN 2 (as listed on original SLRP application)

Lending institution name: _____

Loan account no.: _____ Type of loan (e.g., GSL, NDSL, HEAL): _____

Original Loan Amount: _____ Current loan balance: _____

LOAN 3 (as listed on original SLRP application)

Lending institution name: _____

Loan account no.: _____ Type of loan (e.g., GSL, NDSL, HEAL): _____

Original Loan Amount: _____ Current loan balance: _____

LOAN 4 (as listed on original SLRP application)

Lending institution name: _____

Loan account no.: _____ Type of loan (e.g., GSL, NDSL, HEAL): _____

Original Loan Amount: _____ Current loan balance: _____

LOAN 5 (as listed on original SLRP application)

Lending institution name: _____

Loan account no.: _____ Type of loan (e.g., GSL, NDSL, HEAL): _____

Original Loan Amount: _____ Current loan balance: _____

LOAN 6 (as listed on original SLRP application)

Lending institution name: _____

Loan account no.: _____ Type of loan (e.g., GSL, NDSL, HEAL): _____

Original Loan Amount: _____ Current loan balance: _____

LOAN 7 (as listed on original SLRP application)

Lending institution name: _____

Loan account no.: _____ Type of loan (e.g., GSL, NDSL, HEAL): _____

Original Loan Amount: _____ Current loan balance: _____

LOAN 8 (as listed on original SLRP application)

Lending institution name: _____

Loan account no.: _____ Type of loan (e.g., GSL, NDSL, HEAL): _____

Original Loan Amount: _____ Current loan balance: _____

HEALTH CARE PROFESSIONAL APPLICATION SIGNATURE

I have read and understand the *Overview and Guidance Document* which describes the requirements of the Kansas State Loan Repayment Program (SLRP) and affirm that I meet the qualifications for continued participation in the program. I understand that the information I have provided is subject to verification and providing willfully false information will result in disqualification from the SLRP.

I certify that the information provided is accurate and complete to the best of my knowledge.

Printed Name of Health Care Professional

Date

Signature of Health Care Professional

Printed Name of Authorized Practice Site Representative

Date

Signature of Authorized Practice Site Representative

Submit all documents to:
State Loan Repayment Program
Office of Primary Care and Rural Health
Bureau of Community Health Systems
1000 SW Jackson St, Suite 340
Topeka KS 66612-1365
Phone: 785-296-3135