PRIMARY CARE LOAN PROGRAM
POST-RESIDENCY CERTIFICATION FORM

As a Primary Care Loan recipient, you are required to practice primary health care. Please complete and return this form. An annual self certification is required.

Name: _____SID/SSN_____

Home Address: _____

Name and Address of Employer: _____

_____

Home phone number: _____Work phone number: _____

CURRENT PRACTICE

____ Family Medicine

____ General Internal Medicine

____ General Pediatrics

____ Preventive Medicine

____ Osteopathic General Practice

____General Dentistry

BORROWER CERTIFICATION
I certify that the information contained on this Certification Form is accurate and that I am in compliance with the obligations specified in my Primary Care Loan Promissory Note for Primary Health Care Service.

_____ _____
Signature Date

SEND FORMS TO:

University Accounting Services
4099 McEwen Rd. Suite 700 B,
Farmers Branch, TX 75244

Indiana University
University Collections and Loan Services
1024 East Third Street
Bloomington, IN 47405