US DEPARTMENT OF HEALTH AND HUMAN SERVICES PUBLIC
HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
BUREAU OF HEALTH WORKFORCE
5600 FISHERS LANE, PARKLAWN BUILDING, ROCKVILLE, MARYLAND 20857

PLEASE SUBMIT THIS FORM TO THE LENDING SCHOOL

NFLP REQUEST FOR POSTPONEMENT OF INSTALLMENT PAYMENT

INSTRUCTIONS: A Nurse Faculty Loan may be postponed, in lieu of payment in accordance with the repayment schedule established by the school from which the loan was made, only if the borrower is employed full-time as a faculty at an accredited school of nursing (as described in the most recent NFLP notice of funding opportunity and requests partial cancellation of his or her loan at the end of each complete year of such employment. Multiple forms may be used for multiple employment as described in the most NFLP notice of funding opportunity.

The borrower must submit two (2) copies of this form 30 days after the end of the 12 -month employment grace period. This form must be filed annually, in lieu of payment; subsequent requests for postponement of installment payment must be filed 30 days before the expiration date of the initial request for postponement each year of employment. It is the responsibility of the borrower seeking postponement of installment payment of loan to return this form properly executed to the school from which the loan was made.

IMPORTANT NOTE: Should you terminate full-time employment as nurse faculty the installment repayment(s) is immediately due and payable to the lending school.

NAME AND ADDRESS OF SCHOOL FROM WHICH LOAN WAS MADE (Include Zip Code)	**NAME AND ADDRESS OF BORROWER *(Include Zip Code)***
	DATE GRADUATED

PART I – CERTIFICATION OF EMPLOYMENT *(To be completed by Borrower)*

NAME AND ADDRESS OF EMPLOYER	**TITLE OF POSITION**	
	EMPLOYMENT START DATE (Month, Day, Year)	
	UNPAID LOAN BALANCE (PRINCIPAL/INTEREST)	**DUE DATE**

I certify that I am employed full-time as nurse faculty as described in the most recent NFLP notice of funding opportunity and as indicated above and expect to complete one year of such employment on_____ (month-day-year), at which time I shall secure cancellation of a portion of my loan in accordance with the Section 846A of the Public Health Service Act

SIGNATURE OF BORROWER	**DATE**

PART II – CERTIFICATION OF EMPLOYMENT *(To be completed by Employer)*

I hereby certify that the above statements concerning service of the above-named borrower as full-time nurse faculty or clinical educator/preceptor are true and correct.

NAME AND ADDRESS OF EMPLOYER	**SIGNATURE OF AUTHORIZED OFFICIAL**
	TITLE
CHECK: ☐ Public ☐ Private for Profit ☐ Private not for Profit	**DATE**

Please submit completed form to:

ECSI
PO Box 1289
Moon Township, PA 15108

OR

Indiana University
1024 E 3rd Street Room 122
Bloomington, IN 47405