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 to avoid interest penalty.

Name: _____ Last 4 SSN: _____

Cell/Home Phone: _____ Student ID: _____

Home Address: _____

Name of Employer: _____ Work Phone: _____

Employer Address: _____

CURRENT PRACTICE

_____ Family Medicine

_____ General Internal Medicine

_____ General Pediatrics

_____ Preventative 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

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