West Virginia Department of HEALTH
BUREAU FOR PUBLIC HEALTH

Revised February 2025

Checklist for State Loan Repayment Program (SLRP) Application:

- ☐ All portions of application are complete. (Incomplete applications will be denied.)
- ☐ Copy of citizenship papers are attached, if needed.
- ☐ Copy of employment contract. (If not attached the application will be denied.)
- ☐ Copy of sliding fee schedule. (If not attached the application will be denied.)
- ☐ Copy of documentation needed in Student Loan Balance section. (If not attached the application will be denied.)

Email is the preferred method of receipt for completed applications with attachments. Send to alexis.s.gannon@wv.gov.

If you submit your application by email and do not receive a confirmation of receipt within three business days, call the State Office of Rural Health at 304-352-6035. If no one is available to answer the call, please leave a voice message.

Completed applications with attachments may also be sent via U.S. Mail to:

State Loan Repayment Program
State Office of Rural Health
Bureau for Public Health
WV Department of Health
350 Capitol Street, Room 515
Charleston, WV 25301

For questions, call 304-352-6035

INCOMPLETE APPLICATIONS WILL BE RETURNED.

APPLICATIONS WILL BE ACCEPTED 3/1/2025 THROUGH APRIL 4/30/2025.

PERSONAL INFORMATION		
Last name	First name	Middle name
OTHER NAMES USED:		
Last name	First name	Middle name
TELEPHONE: (*REQUIRED*)		
Cell phone		
DATE OF BIRTH:		
Month	Day	Year
CURRENT HOME ADDRESS:		
Number and street		Apt. No.
City	State	Zip Code
EMAIL ADDRESS:		
PLACE OF BIRTH:		
City	State	Country
ARE YOU A CITIZEN OF THE UNITED STATES? ☐ **YES** ☐ **NO**		
ONLY NATIVE OR NATURALIZED U.S. CITIZENS ARE ELIGIBLE UNDER THIS PROGRAM.		
CURRENT EMPLOYER: ***Attach a copy of current employment contract.***		**DATE EMPLOYED:**
EMPLOYER FEIN #:		**WORK TELEPHONE:**
FACILITY CONTACT EMAIL:		**FACILITY CONTACT TELEPHONE:**
EXECUTIVE DIRECTOR'S NAME:		
CURRENT WORK ADDRESS:		
Number and street		Apt. No.
City and County	State	Zip Code *(include all nine digits)*

Type of provider: Mark type with an X

___ Allopathic physician
___ Certified nurse midwife
___ Dentist
___ Nurse practitioner
___ Osteopathic physician
___ Pharmacist
___ Physician assistant
___ Clinical psychologist
___ Substance Use Disorder counselor

Specialties: Mark specialties with an X

___ Adult
___ Family practice
___ General practice
___ Geriatrics
___ Internal medicine
___ OB/GYN
___ Pediatrics
___ Psychiatry
___ Psychology
___ Dentistry
___ Women's health
___ NONE

AMOUNT OF STUDENT LOAN BALANCE: ***Attach a copy of loan balances for verification.***		
LANGUAGES KNOWN OTHER THAN ENGLISH:		
Read	Write	Speak (fluently)

DO YOU HAVE AN EXISTING SERVICE OBLIGATION?	☐ **YES**	☐ **NO**
HAVE YOU HAD A SERVICE OBLIGATION IN THE PAST?	☐ **YES**	☐ **NO**
IF YES, NAME OF PROGRAM:		
ADDRESS OF THE PROGRAM:		
CONTACT PERSON:	**CONTACT PHONE NUMBER:**	
TERMS OF OBLIGATION:		
ARE YOU IN DEFAULT ON THIS OBLIGATION?	☐ **YES**	**NO**
WHEN WILL THE OBLIGATION BE COMPLETED?		
WHEN WILL YOU BE AVAILABLE TO PRACTICE UNDER THE SLRP PROGRAM?		
PROFESSIONAL SCHOOL FROM WHICH YOU GRADUATED: Street City State Zip Code		**DATE OF GRADUATION:** Month/Day/Year
RESIDENCY OR PROGRAM NAME AND LOCATION:		
ADDRESS Street City State Zip Code		
ARE YOU BOARD CERTIFIED OR BOARD ELIGIBLE?	**YES**	☐ **NO**
CREDENTIALS (required before beginning service)		
DO YOU PRESENTLY HOLD A LICENSE, REGISTRATION, AND/OR CERTIFICATION TO PRACTICE IN WEST VIRGINIA?		
☐ **YES** ☐ **NO**	**License #**	**NPI #**
INDICATE STATE(S):		
NOTE ANY LICENSURE RESTRICTIONS:		
STATE OR REGIONAL BOARD:		
NATIONAL CERTIFICATION:		
PART I AND II NATIONAL BOARDS:		
PART III OF NATIONAL BOARDS:		
OTHER (Specify): *If more space is needed, use a continuation sheet, type name at the top of each page, and attach.*		
DO YOU PROVIDE SUBSTANCE USE DISORDER (SUD) SERVICES?	**YES**	☐ **NO**
DO YOU HAVE A SUD LICENSE OR CERTIFICATION ?	**YES**	☐ **NO**
ARE YOU A DATA 2000 WAIVER PROVIDER?	**YES**	☐ **NO**

DESCRIBE YOUR PRACTICE EXPERIENCE OVER THE LAST 5 YEARS.

PERCENTAGE OF PRACTICE TIME:

Office-based **Hospital-based**

Administration **Teaching**

CURRENT STAFFING LEVELS	QUANTITY	FULL TIME EQUIVALENT
Physicians (FP, IM, PED, OB/GYN)		
Nurse practitioners (FNP, ANP, PNP, OB/GYN, ER)		
Physician assistants (FP, IM, PED, OB/GYN, ER)		
Certified nurse midwives		

PATIENTS BY INSURANCE COVERAGE FOR PAST TWELVE (12) MONTHS	NUMBER OF PATIENTS
Medicare	
Medicaid	
CHIP	
Insured	
Underinsured	
Uninsured/private pay	

After fulfilling your WV SLRP service, do you intend to continue practicing in a medically underserved or Health Professional Shortage Area (HPSA)? Please check the appropriate space below.

- ☐ I do not intend to continue practicing in a HPSA after I have fulfilled my WV SLRP service.
- ☐ I am undecided as to whether I am going to continue practicing in a HPSA after I have fulfilled my WV SLRP service.
- ☐ I plan to continue practicing in a HPSA for one or two years after I have fulfilled my WV SLRP service.
- ☐ I plan to continue practicing in a HPSA for more than two years after I have fulfilled by WV SLRP service.

PROVIDE DOCUMENTATION OF PROFESSIONAL ACHIEVEMENTS AS ATTACHMENTS.

ARE YOU CURRENTLY OF HAVE YOU BEEN A MEMBER OF THE U.S. MILITARY OR NATIONAL GUARD?

YES ☐ **NO**

PLEASE PROVIDE A NARRATIVE OF 100 WORDS OR LESS REGARDING YOUR COMMITMENT TO PRACTICE IN A MEDICALLY UNDERSERVED AREA.

If more space is needed, use a continuation sheet, type your name at the top of each page, and attach it to your application.

PROFESSIONAL REFERENCE INFORMATION (Confidential)

1. Reference Name _____

   Position or Title _____ Telephone _____

   Address _____

2. Reference Name _____

   Position or Title _____ Telephone _____

   Address _____

3. Reference Name _____

   Position or Title _____ Telephone _____

   Address _____

The following information is voluntary and will be used solely by the program; however, your cooperation is essential to ensure adequate evaluation of the State Loan Repayment Program.

☐ Male ☐ Female

Please mark the item below which best describes your primary racial/ethnic background: CHECK ALL that apply.

- ☐ Black
- ☐ Hispanic
- ☐ White
- ☐ American Indian or Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ Other

CERTIFICATION

I certify that the information in this application is accurate and complete to the best of my knowledge and belief. I understand that information included in this application may be investigated and that any willfully false representation is sufficient cause for rejection of this application, or, if awarded loan repayment funds, that I am liable for repayment of all awarded funds and, further, that any false statement herein may be punished as a felony. (**SIGN YOUR FULL NAME.)**

_____ _____

SIGNATURE **DATE**

_____

Print your name with credential initials

FACILITY/EMPLOYER ACCEPTANCE

Candidate's name NPI #

- ☐ Declarations (Sub-recipient Grant Agreement will be made in the name of the employer. (Executive director/CEO must check each statement.)
- ☐ This grant award will not be used for supplemental income for the Candidate named in this application.
- ☐ The Candidate will provide primary care services with a minimum of forty (40) hours a week, forty-five (45) weeks a year, at the practice site listed in this application. The Candidate will provide twenty (20) hours a week if award is for part-time work.
- ☐ The Candidate named in this application will practice only at the site(s) listed in this application.
- ☐ Grant funds, if received, will be disbursed to the Candidate's lending institution(s) where medical education loan balance(s) exist within fourteen (14) working days of the Employer's receipt of funds from the Department.
- ☐ Within Sixty (60) days of disbursement, the Employer will mail a copy of the canceled check or electronic payment to the Department.
- ☐ A copy of the employment agreement between the Employer and the Candidate is enclosed.
- ☐ The Employer will notify the Department immediately upon the departure of the Candidate.

I certify that the information given in this application is accurate and complete to the best of my knowledge and belief and further, that any false statement herein may be punished as a felony. I understand this application may be investigated and that any willfully false representation is sufficient cause for rejection of this application. If our facility is awarded a sub-recipient grant, it is liable for repayment of all awarded funds plus 20% penalty to the Department. It is the responsibility of our facility to recoup funds from the recipient.

Executive director (or designee) signature/date

Print name of executive director (or designee)

Print name of chief financial officer (for Grant Agreement purposes only)

Print email and phone number for chief financial officer (for Grant Agreement purposes only)