Checklist for Recruitment and Retention Community Project (RRCP) Application:

___ All portions of application are complete.
___ Copy of employment contract.
___ Copy of sliding fee schedule.
___ Copy of documentation needed in Student Loan Balance section.
___ All signatures are in blue ink.

Email is the preferred method of receipt for completed applications with attachments. Send to Danielle.R.Kirby@wv.gov

If you submit your application by email and do not receive confirmation of receipt within three business days, call the State Office of Rural Health at 304-352-6018. 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:

Recruitment and Retention Community Project
State Office of Rural Health
Bureau for Public Health
WV Department of Health
350 Capitol Street, Room 515
Charleston, WV 25301

For questions, call 304-352-6018

INCOMPLETE APPLICATIONS WILL BE RETURNED.

APPLICATIONS WILL BE ACCEPTED 3/1/2026 THROUGH 4/30/2026.

Revised February 2026

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? ***(ONLY NATIVE OR NATURALIZED U.S. CITIZENS ARE ELIGIBLE UNDER THIS PROGRAM)***	**___YES**	**___NO**
CURRENT EMPLOYER:		**DATE EMPLOYED:**
(Attach a copy of current employment contract)		
EMPLOYER FEIN #:		**WORK TELEPHONE:**
FACILITY CONTACT NAME 1:		**FACILITY CONTACT TELEPHONE 1:**
FACILITY CONTACT EMAIL 1:		
FACILITY CONTACT NAME 2:		**FACILITY CONTACT TELEPHONE 2:**
FACILITY CONTACT EMAIL 2:		
EXECUTIVE DIRECTOR'S NAME & EMAIL:		
CURRENT PRACTICE ADDRESS:		
Number and street		Apt. No.
City and County	State	Zip Code (include all nine digits)

Type of provider:	**Specialties:**
___ Allopathic physician ___ Certified nurse midwife ___ Dentist ___ Nurse practitioner ___ Osteopathic physician ___ Pharmacist ___ Physician assistant ___ Clinical psychologist	___ 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 RRCP PROGRAM?

NAME OF PROFESSIONAL SCHOOL FROM WHICH YOU GRADUATED:
ADDRESS

_____	_____	_____	_____	**DATE OF GRADUATION:**
Street	City	State	Zip Code	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 your name at the top of each page, and attach it to application.)

DO YOU PROVIDE SUBSTANCE USE DISORDER (SUD) SERVICES?	**___YES**	**___NO**
DO YOU HAVE A SUD LICENSE OR CERTIFICATION ?	**___YES**	**___NO**

DESCRIBE YOUR PRACTICE EXPERIENCE OVER THE LAST 5 YEARS.

PERCENTAGE OF PRACTICE TIME:

Office-based _____ **Hospital-based ____**

Administration _____ **Teaching ____**

CURRENT STAFFING LEVELS OF PRIMARY PRACTICE	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 AT PRIMARY PRACTICE SITE	NUMBER OF PATIENTS
Medicare	
Medicaid	
CHIP	
Insured	
Underinsured	
Uninsured/private pay	

After fulfilling your WV RRCP 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 RRCP service.

___I am undecided as to whether I am going to continue practicing in a HPSA after I have fulfilled my WV RRCP service.

___I plan to continue practicing in a HPSA for one or two years after I have fulfilled my WV RRCP service.

___I plan to continue practicing in a HPSA for more than two years after I have fulfilled my WV RRCP 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 Recruitment and Retention Community Project.

____ 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 IN BLUE INK**)

_____ _____

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 initial each statement.)

____Unless used for retention purposes, the 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 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 thirty (30) 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
(**SIGN YOUR NAME IN BLUE INK**)

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)