

**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 Service, LLC.
P.O. Box 918
Brookfield, WI 53008-0918
800-723-2210



An OSI Company