



OKLAHOMA
State Department
of Health

**CERTIFICATION OF
SCHOOL LOAN**
OKLAHOMA DENTAL LOAN REPAYMENT PROGRAM

Oklahoma State Dept. of Health
Dental Health Service
123 Robert S Kerr Ave, Ste 1702
Oklahoma City, OK 73102
405-426-8460
ODLRP@health.ok.gov

Applicant Information (Please type or print in black or blue ink.)

Last Name	First Name	MI
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(COPY THIS PAGE IF NECESSARY TO LIST ADDITIONAL EDUCATIONAL DEBT) **If you have more than one educational loan with a particular lender, please total the amount of loans with that lender and record a combined figure.**

Lending Institution: _____

Account Number: _____

Month and Year loan repayment started/will start: _____

\$ _____	_____	_____
Current Outstanding Balance	Monthly Due Date	Monthly Payment

Lending Institution: _____

Account number: _____

Month and Year loan repayment started/will start: _____

\$ _____	_____	_____
Current Outstanding Balance	Monthly Due Date	Monthly Payment

Lending Institution: _____

Account number: _____

Month and Year loan repayment started/will start: _____

\$ _____	_____	_____
Current Outstanding Balance	Monthly Due Date	Monthly Payment



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LENDER VERIFICATION
(TO BE COMPLETED BY EACH LENDER)
Please copy additional forms if necessary.
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Dental Health Service
123 Robert S Kerr Ave, Ste 1702
Oklahoma City, OK 73102
405-426-8460
ODLRP@health.ok.gov

Name: _____ Social Security Number: _____

I authorize my lender, _____, to provide the loan information requested by the Oklahoma Dental Loan Repayment Program.

Applicant Signature

Date

This section to be completed by the lending institution. Please type or print in black or blue ink.

Name of Applicant

Account Number

Outstanding Principle

Outstanding Interest

Monthly payment information is necessary although a loan may be in deferment at the present time. If a repayment schedule has not yet been determined, please provide an estimate of the monthly payment.

Is this loan for dental school education expenses, only? _____ Yes _____ No

Please indicate payment schedule: _____ Monthly _____ Quarterly

This loan is: _____ Current _____ In Default _____ In Deferment

Has this loan ever been in default? _____ Yes _____ No

Name of Lender to Whom Payments will be Made

Printed Name of Official

Federal ID Number of Lender

Title of Official

Address

Signature of Official

City State Zip

Telephone Number

Date

Please return this form to:

**OKLAHOMA STATE DEPARTMENT OF HEALTH
OKLAHOMA DENTAL LOAN REPAYMENT PROGRAM
DENTAL HEALTH SERVICE
123 ROBERT S KERR AVE, STE 1702
OKLAHOMA CITY, OK 73102**