

**HEALTH CARE WORKFORCE TRAINING COMMISSION
Physician/Community Match Program**

APPLICATION

Name _____ M.D or D.O. SS# _____
(First, Middle, Last)

Specialty _____ License # _____ Maiden Name _____

Address _____
(Street/P.O. Box, City, State and Zip) (E-mail address)

Phone Number () _____ Mobile Number () _____

Date of Birth ____/____/____ Hometown _____ Marital Status _____

Spouse Name _____ Maiden Name _____ SS# _____

Spouse Occupation _____ Spouse Hometown _____

Number of Children _____ Ages _____

Applicant: Parents' Name (or Living Relative), Address and Phone _____

Medical College(s), City and State _____ Dates Attended _____

Postgraduate Training Institution(s), City and State _____ Dates Attended _____

Anticipated Date of Completion of Postgraduate Training (Month/Year) _____

Or current practice location _____

In what extra-curricular activities (community, hobbies, avocational) have you participated while in medical school and/or postgraduate training?

Physician/Community Match Program Application Continued

Do you have a rural community sponsor? Yes No

If yes, name of town _____

What date will you begin practicing medicine in the community? _____

Explain your interest in the sponsoring community/state area choice:

Do you presently have any scholarships or loans which have a practice obligation?

Yes No

Are you a previous HWTC Participant? Yes No

If yes, please explain _____

Do you presently have a medical license in another state(s)? Yes No

If yes, which state(s) & # (s) _____

Do you now, or have you ever had a restricted license? Yes No

If yes, please explain _____

I understand this program is designed to bring additional physicians to the rural and underserved areas of Oklahoma. I acknowledge I am not currently practicing in a rural Oklahoma Community. _____

The Health Care Workforce Training Commission is given permission to contact any parties or to obtain the sources of information, which it deems necessary to verify my eligibility for this scholarship/loan.

The Health Care Workforce Training Commission, in compliance with Title VI of the Civil Rights Act of 1974 and Title IX of the Education Amendments of 1972 (Higher Education Act), does not discriminate on the basis of race, color, national origin or sex in any of its policies, practices, or procedures. This provision includes, but is not limited to, employment and financial services.

I hereby declare that the information contained in this application is true and correct to the best of my knowledge.

Please include a head and shoulders photo with your application

Signature of Applicant _____ 

Date of Application _____

Please return to:

Health Care Workforce Training Commission
119 N Robinson Avenue, Suite 520
Oklahoma City, Oklahoma 73102
(405) 604-0020 FAX (405) 768-2263

