

**ATTENTION**

This program requires the physician to accept **Sooner Care** and **Medicare** patients. Family Medicine, Pediatric and General Internal Medicine physicians are required to register as a Medicaid Medical Home. This program is provided by a public and private partnership.



**Health Care Workforce  
Training Commission**

**Physician Loan Repayment Program  
Candidate Application**

Loan Repayment for primary care physicians practicing in Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs) or other rural communities approved by the Health Care Workforce Training Commission

**Please submit a head & shoulders photo with this application.**

Name \_\_\_\_\_ M.D. or D.O. SS# \_\_\_\_\_  
(First, Middle, Last) (Circle one)

Medical License Number(s) \_\_\_\_\_ Specialty \_\_\_\_\_

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

Phone Number ( ) \_\_\_\_\_ Cell Phone Number ( ) \_\_\_\_\_

Business Address \_\_\_\_\_ Bus. Phone ( ) \_\_\_\_\_  
(Street/P.O. Box, City, State and Zip)

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ 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

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Residency Training Institution, City and State

Dates Attended

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List the community name and facility where you plan to practice: (Application is for the stated community only)

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Name of community sponsor and contact person: \_\_\_\_\_

\_\_\_\_\_ Projected start date: \_\_\_\_\_

Explain your community area choice:

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Do you presently have any scholarships/loans that have a practice obligation? \_\_\_\_ Yes \_\_\_\_ No  
Participant in Federal Sponsored Loan Repayment? \_\_\_\_ Yes \_\_\_\_ No

If yes, please explain \_\_\_\_\_

Are you a previous HWTC Participant? \_\_\_\_ Yes \_\_\_\_ No

Please provide the amount owed for educational loans: \_\_\_\_\_

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.

Signature of Applicant \_\_\_\_\_ 

Date of Application \_\_\_\_\_

**Please return to:**

**Health Care Workforce Training Commission  
119 North Robinson Avenue, Suite 520  
Oklahoma City, Oklahoma 73102-4603  
(405) 604-0020 FAX (405) 768-2263**

10/6/2022

