**ATTENTION**

This program requires the physician assistant 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.

OKLAHOMA
Health Care Workforce
Training Commission

# Health Care Workforce Training Commission

**Physician Assistant Loan Repayment Program**
**Candidate Application**

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

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

Name _____ SS#_____
(First, Middle, Last)

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 _____

_____

| Undergraduate College(s), City and State | Dates Attended |
|---|---|
| | |
| | |

| Physician Assistant Training, City and State | Dates Attended |
|---|---|
| | |
| | |

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

_____

Name of community sponsor and contact person: _____

_____Projected start date: _____

Explain your community area choice:

_____

Do you presently have any scholarships or loans which have a practice obligation?
_____Yes _____No Participate in any Federal Sponsored Loan Repayment? _____Yes _____No

If yes, please explain _____

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**
**(405) 604-0020 FAX (405) 768-2263**

**Rev. 10/2022**