



**PMTTC**

## Physician Manpower Training Commission

### ATTENTION

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

### 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 Physician Manpower 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 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 Physician Manpower 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 Physician Manpower 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:**

**Physician Manpower Training Commission  
119 North Robinson Avenue, Suite 520  
Oklahoma City, Oklahoma 73102  
(405) 604-0020 FAX (405) 768-2263**

**3/10/2020**