

ARIZONA STATE LOAN REPAYMENT PROGRAMS

PROVIDER APPLICATION



Mail completed *Application* to:

Arizona Department of Health Services
Bureau of Health Systems Development
Attn: Loan Repayment Program Manager
150 N 18th Ave Suite 300
Phoenix, Arizona 85007

Application Period:
December 16 – March 15
March 16 - June 15
June 16 - September 15
September 16 - December 15

Please direct all inquiries to:

Ana Roscetti, MPH

PH: 602-542-1066

FX: 602-542-2011

ana.lyn.roscetti@azdhs.gov

****Be sure to include copies of requested additional information****

SECTION II. EDUCATION AND CERTIFICATIONS

****PLEASE PROVIDE COPIES OF ALL LICENSES, CERTIFICATES, AND A CURRENT CURRICULUM VITAE****

A. Identify the professional school from which you received your professional degree/certificate.

Name of School: _____

Location of School: _____
(City) (State)

In what year did begin your work for this degree/certificate: _____

In what year did you receive this degree/certificate: _____

B. Post-Graduate Professional Training:

Have you completed a residency program? Yes_____ No_____ If yes, provide the following information:

Name and location of the professional residency program from which you received your training:

(Name of Program)

(City) (State)

Begin Date:_____ Completion Date:_____

(Month/Year) (Month/Year)

Have you completed an Internship? Yes _____ No_____ If yes, provide the following information:

Name and location of the organization/facility where you performed your internship:

(Name of Program)

(City) (State)

Begin Date:_____ Completion Date:_____

(Month/Year) (Month/Year)

C. Undergraduate Education:

Name of School: _____

Location of School: _____
(City) (State)

Degree _____ Major (Area of Concentration) _____

Begin Date:_____ Completion Date:_____

(Month/Year) (Month/Year)

D. Licensing/Certification:

Are you currently holding a permanent license in the State of Arizona? Yes_____ No_____

If no, when do you plan to take the examination for licensure? _____

Do you hold a license in any state other than Arizona? Yes_____ No_____

If yes, please provide the following information:

State of Licensing:_____ License Number:_____

Date of Original Licensure: Start: _____ Current Expiration: _____

Please describe any license restrictions: _____

Certifications (Including Board Certification):

Board certified? Yes _____ No _____

For Advance Practice Providers (PA and NP including Nurse Midwives, do you have a national certification to practice? Yes _____ No _____

For Behavioral Health Providers, do you have a national or state certification to practice?

Yes _____ No _____

For Pharmacists, do you have a national certification to practice?

Yes _____ No _____

Type of Certificate: _____

State of Certification: _____ Certificate Number: _____

Date of Original Certification: _____ Current Expiration: _____

Please describe any certification restrictions: _____

If not yet board certified, please send a copy of your acceptance letter from the examining authority.

SECTION III. PROFESSIONAL EMPLOYMENT EXPERIENCE

Please provide the following information. List the most recent or current employer first.

(Employer and Name of the Executive Director/Senior Manager)

(Site Name) Dates employed _____

(Street Address)

(City) (State/Province) (Zip Code)

Telephone Number: _____ May we contact? _____

(Employer and Name of the Executive Director/Senior Manager)

(Site Name) Dates employed _____

(Street Address)

(City) (State/Province) (Zip Code)

Telephone Number: _____ May we contact? _____

(Employer and Name of the Executive Director/Senior Manager)

_____ Dates employed _____
(Site Name)

(Street Address)

(City) (State/Province) (Zip Code)

Telephone Number: _____ May we contact? _____

If you would like to provide additional employment experience, attach information on a separate piece of paper, with your name and social security number at the top.

SECTION IV. PROFESSIONAL REFERENCE

Please provide the following information about three professional references not provided elsewhere in this application.

Reference Name: _____ Title: _____

Complete Address: _____

(City) (State) (Zip Code) (Telephone)

Reference Name: _____ Title: _____

Complete Address: _____

(City) (State) (Zip Code) (Telephone)

Reference Name: _____ Title: _____

Complete Address: _____

(City) (State) (Zip Code) (Telephone)

SECTION V. EXISTING OR PRIOR COMMITMENTS

- Do you have an existing professional service obligation to a Federal, State, or other entity? *** Yes _____ No _____

*** Other professional service obligations that preclude an applicant from being eligible for the LRP include, but are not limited to, an active duty military service obligation, National Health Service Corps (NHSC) Loan Repayment Program (LRP), NHSC Scholarship Program, Nurse Education LRP or Nursing Scholarship Program obligation, unless that service obligation will be completely satisfied before the contract has been signed.

If yes, Name of Program: _____
Contact Person: _____
Contact Telephone Number: _____
Complete Contact Address: _____

Terms of obligation: _____

- Are you delinquent on any financial obligation (i.e., taxes, student or home mortgage loans, or child support**)? Yes _____ No _____
** In keeping with the President’s Executive Orders concerning compliance with child support orders, all applicants must be current on all ordered support payments.

- Are you subject to any judgment liens for a federal debt to the United States? Yes _____ No _____
- Were/Are you in default of any professional service obligation? **** Yes _____ No _____

**** e.g. Have you failed to begin or complete service or failed to fulfill service requirements.

If yes, Name of Program: _____
Contact Person: _____
Contact Telephone Number: _____
Complete Contact Address: _____

Terms of obligation: _____

SECTION VI. SERVICE SITE COMMITMENT

Attach a copy of the signed employment contract for the current or prospective service site. Contract must indicate that the required full-time or half-time (40 hours or 20 hours minimum), primary care services will be delivered at the approved service site for a minimum of 24 months.

Service Site: _____

Service under the employment contract is to commence on _____ and end on _____

Unless an obstetrician or nurse midwife, providers must work a t least 32 of the minimum 40 hours per week providing primary care services at the approved service site during scheduled office hours. If an obstetrician or nurse midwife, providers must work a t least 21 of the minimum 40 hours per week providing ambulatory care services at the approved service site during scheduled office hours.

SECTION VII. SERVICE TO THE UNDERSERVED POPULATIONS

Do you have experience serving the medically underserved populations? Yes ____ No ____

If yes, please explain and limit your response to the space provided.