

REQUEST FOR SUSPENSION ARIZONA STATE LOAN REPAYMENT PROGRAMS

Request Date: _____

[Please read R9-15-212, Arizona Administrative Code related to Contract Suspension.](#)

I have read the section R9-15-212 of the State Loan Repayment Program's administrative code. ____ Initials

Per R9-15-212 (D), a primary care provider may request an initial suspension of the contract for up to six months. If the primary care provider is unable to resume providing primary care services by the end of the initial suspension period, the primary care provider may request an additional six-month contract suspension for a total maximum allowable contract suspension of 12 months.

Please select one:

_____ I am requesting to suspend my LRP contract for an initial 6 months from Start Date _____
to End Date _____.

_____ I am requesting to extend my contract suspension period for an additional six months from the initial
approved suspension period end date of _____ to a New End Date of _____.

PRIMARY CARE PROVIDER INFORMATION

Name (Last, First): _____

Address: _____

Home Phone Number: _____ Daytime: _____

Email Address: _____

SERVICE SITE INFORMATION

Name of Service Site: _____

Service Site Address: _____

Authorized Person to Act on Behalf of the Service Site: _____

Phone Number: _____ Email Address: _____

SUSPENSION REQUEST

Please indicate the reason for the request for suspension:

_____ I have a health condition that restricts my ability to complete the terms of my contract.

Brief Detail: _____

REQUEST FOR SUSPENSION

ARIZONA STATE LOAN REPAYMENT PROGRAMS

_____ I have a member in my immediate family who has a health condition that restricts my ability to complete the terms of my contract.

Note: Immediate Family is defined in R9-15-101 ([Hyperlink this](#)). A suspension request may be considered for a medical condition of a member of an immediate family that meets this definition.

Brief Detail: _____

_____ I am transferring to a different service site with which I anticipate a gap in my LRP service.

CERTIFICATION and AUTHORIZATION

I hereby certify that the information contained in this request for suspension is true and accurate, and hereby authorize the Arizona Department of Health Services (ADHS) or its designee to verify all information presented herein. _____ Initials

I hereby authorize the ADHS to request supplemental information/documentation from me in order to assist with ADHS' review and decision regarding my suspension request. _____ Initials

I understand that if my request for suspension is granted, ADHS will not disburse loan repayment to my lender(s) and that I will be responsible for making loan repayments to my lender during the suspension period. _____ Initials

I understand that if my request for suspension due to a transfer to a different service site is granted, I am responsible to report to ADHS any progress made in identifying a service site during my suspension period. _____ Initials or N/A if not applicable

I understand that if my request for suspension is granted and if during the suspension period, I am due for renewing my LRP contract, I may submit a renewal application per R9-15-212 for consideration for a contract renewal for an additional year. _____ Initials

I understand that per R9-15-212 (J), I must resume LRP service by the end of the suspension period or I will be in default and will be charged to pay liquidated damages per R9-15-213. _____ Initials

Primary Care Provider's Signature _____ Date Signed _____