DEPARTMENT OF HEALTH
OFFICE OF RURAL HEALTH AND PRIMARY CARE

Minnesota State Loan Repayment Program
Site Notification and Verification (PT)

I, _____(print name of authorized site representative), understand that

_____(clinician) has accepted an award through the Minnesota State Loan Repayment Program (SLRP) and has signed a two-year part-time service agreement with the State.

The service agreement under this program obligates the provider to a number of terms including, but not limited to, the requirements listed below.

Part-time SLRP participants must be employed a minimum of 20 hours per week, of which 16 hours must be providing patient primary (medical, dental or mental health) care at the approved clinical outpatient site(s). Additionally, participants must be onsite at least 45 weeks per year. Emergency Department, "on call" coverage and care provided off-site are not considered eligible service to meet the minimum hourly requirement for patient care for this program. As an exception, OB/GYN physicians, family medicine physicians who practice obstetrics on a regular basis, certified nurse midwives and providers of geriatric services may provide up to 5 hours of the 16 minimum patient care hours in other settings as directed by the approved site.

Participants must use loan repayment disbursements from this program to pay designated educational loans. Proof of payment, i.e. payment verification forms, must be submitted to the Minnesota Department of Health per the program agreement.

Participants must submit a Confirmation of Practice form at the start of his or her obligation, annually, and as requested by the State. This confirmation form must be signed by the participant and by an authorized representative of the participant's approved site.

Participants may NOT complete any other service obligation (local, state or federal) while completing the SLRP obligation.

Participants failing to complete the service obligation and/or fully comply with the terms of the agreement will be responsible for serious financial penalties.

Sites that fail to provide employment conditions that satisfy the obligations of the SLRP participant may not be considered for future participation in this program.

As the authorized site representative, I agree to support _____ (clinician) in successfully completing the service obligation and terms set forth by the SLRP agreement with the state.

_____ _____

Signature of Authorized Representative **Date**

_____

Title of Authorized Representative