DEPARTMENT OF HEALTH
OFFICE OF RURAL HEALTH AND PRIMARY CARE

MINNESOTA LOAN FORGIVENESS PROGRAM
DENTIST
APPLICATION FOR 2019

Loan forgiveness for dentists practicing and serving at least 25% of their patients receiving public assistance in Minnesota

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APPLICATION DEADLINE: January 3, 2019 by 4:00pm CST (*must be emailed*)

RETURN APPLICATION AND SUPPORTING DOCUMENTS LISTED ON PAGE 3 TO:

health.loanforgiveness@state.mn.us

If emailing your application is a hardship for you please contact us for an alternate delivery method

An automatic reply receipt will be sent to your email account, but your application must be complete and received by 4:00 pm 1/3/19 to be forwarded to review. To be considered, all required information must be submitted together.

DO NOT SEND MULTIPLE COPIES.

For more information contact:
Brenda Flattum at (651) 201-3870 – brenda.flattum@state.mn.us

Please read the 2019 Loan Forgiveness Program Information Notice on our website for program eligibility and requirements.

APPLICATION CHECKLIST

The application must include the following supporting documents. Incomplete applications will not be fully scored and may not be considered for an award.

- ☐ Application (include license number in appropriate section)
- ☐ Resume or Curriculum Vitae (CV)
- ☐ Reference Letters (1-2)
- ☐ Essay Response

Include **all** information requested or your application will be void.

Personal Information

First Name: Middle Name: Last Name:

Home Address: Home City: Home State:

Home Zip: Home Phone (xxx-xxx-xxxx): Work Phone (xxx-xxx-xxxx):

Email Address: DOB (m/d/yyyy):

Are you currently a Student, Resident, or Licensed General Dentist?

☐ Student ☐ Resident ☐ Licensed Dentist

Dental School

University: University City: University State:

Start Date (m/d/yyyy): Graduation Date (m/d/yyyy): **Approx. total remaining outstanding debt:**

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Training

Residency Program Attending (if applicable): Residency City: Residency State:

Start Date (m/d/yyyy): End Date (m/d/yyyy):

License

Are you Licensed? ☐ Yes ☐ No

Type: State: License Number: Issue Date (m/d/yyyy): Expiration Date (m/d/yyyy): Restrictions (if any):

Do you have any existing service obligation with any federal, state or other entity? ☐ Yes ☐ No

If yes, please describe the obligation and when it will completed (e.g., State Loan Repayment, NHSC, IHS, PSLF):

Do you have a pending application with NHSC, Nurse Corps, IHS? ☐ Yes ☐ No

Place of Employment

Only complete if you are working as a licensed dentist or know your intended service obligation site.

Site Name: Site City: Site County:

Personal Contact

List an individual who will be in contact with you during the next three years to ensure our ability to contact you.

Name (First and Last): Relationship to you: Email Address: Home Phone (xxx-xxx-xxxx):

I certify that the information given in this application and attachments is accurate and complete to the best of my knowledge. I hereby authorize the Minnesota Department of Health to contact references listed in the application for the purpose of obtaining information about my professional qualifications and experience. I understand that the information I have provided is subject to verification, and providing willfully false information will result in disqualification from participation in this program.

Name (First, Middle, Last), original signature required: Date (m/d/yyyy):

ADDITIONAL APPLICATION DOCUMENTS

(1) Resume/CV

Include a resume or CV that describes and details your educational background, dental training and clinical experiences. Include any volunteer experience, and diverse communities or populations served. Specify length of time, location, your capacity and other details of all personal and professional health care experiences and training.

(2) References

Provide letters of reference and support from at least one but no more than two individuals (including your intended service obligation site, if known). Reference letters should be on **letterhead** and include: (1) a statement of the writer's professional relationship to you; (2) an evaluation of your suitability for participation in this program; and (3) the writer's contact information and **signature**. Co-workers that are your peers/equal, parents, friends, clergy and/or classmates are not suitable references. Co-workers who work in the same office but in a different role and/or as a supervisor are fine.

Reference letters should detail how you will satisfy unmet health care needs, your commitment to service, and a description of the service area and population.

(3) Essay

Please provide an essay (two pages or less) describing how you, as a dentist, will address access to health care issues, and how your experiences will change health care outcomes of the patient population you will be serving in the rural community. Note: All applicants have similar education backgrounds; describe what makes you uniquely qualified for this program.

APPLICATION DOCUMENT SHOULD BE NAMED ACCORDINGLY:

Single Attachment, combined documents

2019, first initial, last name, the profession you are applying for.

2019_FIRSTINITALLASTNAME_Dentist_CompleteApp