



## Affidavit of Practice as Allied Health Care Faculty in Minnesota

You are required to complete and return this ORHPC Affidavit of Practice to provide necessary documentation of your service as allied health care faculty in a postsecondary program.

Participant Name: _____	Phone: (____) _____
Address: _____	Cell: (____) _____
City: _____	State: _____ Zip: _____
County: _____	E-Mail: _____
_____ <b>Signature of Participant</b>	

Teaching Site: _____	Phone: (____) _____
Address: _____	
City: _____	State: _____ Zip: _____
County: _____	

<b>To Be Completed by an Authorized Individual at the Practice Site Named Above</b>	
I certify that the above named allied health care faculty was teaching at least 12 credit hours or 720 hours per year (including prep time) at the postsecondary educational facility named above from ____/____/____ to <b>Date</b> ____/____/____. <b>Date</b>	
_____ <b>Printed Name of Authorized Representative</b>	_____ <b>Title of Authorized Representative</b>
_____ <b>Signature of Authorized Representative</b>	____/____/____ <b>Date</b>
<b>Phone:</b> (____) _____	<b>Email Address:</b> _____

**Please return to:** Minnesota Department of Health, Office of Rural Health and Primary Care  
Attn: Loan Forgiveness Program Officer  
P.O. Box 64882 St. Paul, MN 55164-0882  
**Or by Email:** [mohamed.samaha@state.mn.us](mailto:mohamed.samaha@state.mn.us) **Or by Fax** (651) 201-3830

For Questions, please contact Mohamed Samaha at (651) 201-3870 or (800) 366-5424.