



Affidavit of Practice as a State Loan Repayment Program Health Care Provider

You are required to complete and return this ORHPC Affidavit of Practice to provide necessary documentation of your service as a provider in a designated HPSA.

Participant Name: _____	Phone: (____) _____
Address: _____	Cell: (____) _____
City: _____	State: _____ Zip: _____
County: _____	E-Mail: _____
_____ MN License Number: _____	
Signature of Participant	

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

To Be Completed by an Authorized Individual at the Practice Site Named Above	
I certify that the above named provider has worked full time (at least 40 hours per week) from ____/____/____ to <b style="text-align: right;">Date	
____/____/____ for at least 45 weeks per year at the federally designated health professional shortage area site named <b style="text-align: left;">Date	
above. At least 32 hours were providing clinical patient care (21 for OB/GYN physicians and nurse midwives).	
_____	_____
Printed Name of Authorized Representative	Title of Authorized Representative
_____	____/____/____
Signature of Authorized Representative	Date
Phone: (____) _____	Email Address: _____

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 **Or by Fax** (651) 201-3830

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