# MINNESOTA LOAN FORGIVENESS PROGRAM
# PAYMENT VERIFICATION FORM

I declare that all information provided herein is true and complete to the best of my knowledge. I have read, understand, and acknowledge that pursuant to my Agreement, Section III, part 3.2, this form and the documents requested are necessary and required by the Office of Rural Health and Primary Care for purposes of the loan forgiveness program. Failure to provide any of the information requested on this form may result in me being in violation of the Agreement.

Name (First, Middle, Last):

Date (m/d/yyyy):

Provide a **summary** of your loan payments made (to all designated loan servicers). **Include a statement from each loan servicer showing: (1) the loan balance; and (2) the payment history *or* a copy of a cancelled check.** As a loan forgiveness participant, you must provide verification that the full amount of the loan repayment disbursement received by you has been applied toward the designated loans.

| Loan Servicer/Bank | Account # | Total Amount Paid By You | Last Payment Date (m/d/yyyy) | Loan Balance | Date of Loan Balance (m/d/yyyy) |
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| **TOTAL AMOUNT PAID BY YOU TO <u>ALL</u> LOAN SERVICER(S):** **(Must total *at least* the amount paid to you by the State)** | | | | | |

**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:** amy.vallery@state.mn.us **Or by Fax** (651) 201-3830

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