DEPARTMENT OF HEALTH
OFFICE OF RURAL HEALTH AND PRIMARY CARE

Confirmation of Practice Form – Full-Time Practice

Minnesota State Loan Repayment Program

I: (firstname, MI, lastname)

began my service as a half-time (at least 40 hours per week 45 weeks per year) health care provider on: (date) at the approved outpatient clinic site per my Minnesota State Loan Repayment Program Agreement. I have completed my: (check one)

☐ 1st ☐ 2nd year of service, of my two-year obligation.

I agree to notify the Minnesota Office of Rural Health and Primary Care of any changes to the information provided on this form. I will also notify MN ORHPC if there is a change in my intent to practice in Minnesota as warranted in my Minnesota State Loan Forgiveness Program Agreement.

Home address:

City: State Zip Code:

Contact Phone: Email:

Practice Site: Phone: Ext:

Address:

City: State Zip Code:

Participant Signature Date:

The following page is to be completed by an authorized individual at the practice site named above.

I certify that the health care provider named above has worked full-time (defined as 40 hours per week) for at least 45 weeks per year at the approved outpatient clinical site(s) named above. At least 32 hours per week were providing outpatient clinical patient care. (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 11 of the 32 patient care hours at alternative settings.)

From: (date) To: (date)

Printed Name of Authorized Representative Title of Authorized Representative

Phone: Email:

Signature of Authorized Representative Date:

Please return form to:
Minnesota Department of Health
Office of Rural Health and Primary Care
Loan Forgiveness Program Administrator
P.O. Box 64882
St. Paul, MN 55164-0882

For questions, please contact:
Brenda Flattum at (651) 201-3870, or
Angela Lofgren at (651) 201-3854