OMB NO. 0915-0150
Expires: 12/31/09

Faculty Loan Repayment Program (FLRP)
Institution Employment/Loan Repayment Verification Form

The _____ intends to employ
Institution (print or type)
_____ in a faculty position
Applicant (print or type)
(duties primarily consist of teaching in a classroom) for a minimum of 2 years. The position is ___full-time (number of hours ____) or ___ part-time (number of hours ____). This employment must begin on or before September 30, 2009. Employment start date _____. Date Fall Term begins _____. Number of months in an academic year _____. Number of months individual works as a faculty member _____.

Definition of full-time faculty position_____
_____
_____

The institution is accredited by _____

This information is for statistical purposes only. The institution is:

___ Historically Black ___ Hispanic Serving ___ Tribal

Located in a: ___ Medically Underserved Area (MUA) ___ Health Professional Shortage Area (HPSA)

The institution (must check one):

----- has agreed to make payments of principal and interest on the educational loans of the applicant in an amount equal to the amount of such payment(s) made by the HHS Secretary (maximum $40,000 total for 2-year contract period). These payments will be in addition to the applicant's faculty salary and the applicant's salary will be determined without regard to the amount paid by HHS. Attach a copy of the agreement.

OR

----- is unable to make payments of principal and interest on the educational loans of the applicant in an amount equal to the amount of such payment(s) made by HHS and requests a full or partial waiver of this requirement as an undue financial hardship. (The Secretary may waive all or part of the institutional loan repayment requirement if the Secretary determines it will impose an undue financial hardship on the school. The school **must** provide supporting documentation, as specified in the *Applicant Information Bulletin*, to the applicant for submission with his/her application.) (If partial waiver is requested, amount of funds that will be provided by institution per year: _____) Attach a letter requesting a waiver and a copy of the documentation.

Name: _____
(print or type)

Title: _____

Mailing Address: _____

_____

_____

Phone: _____ - _____ - _____ ex _____ Fax : _____ - _____ - _____

E-mail: _____
(print or type)

Signature : _____ Date: _____

(4/09 - DAA, BCRS, HRSA, DHHS)