National Health Service Corps
Loan Repayment Program

U.S. Department of Health and Human Services
Health Resources and Services Administration

NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM SELF-CERTIFICATION FORM

Purpose: Provides for self-certification of specific eligibility and other criteria for applicants to the National Health Service Corps (NHSC) Loan Repayment Program (LRP) and reduces the response and collection burden previously approved under OMB 0915-0127, Expiration U&c[à^¦ 31, 2010.

Applicant Name: ____
(Print First, Middle Initial, Last Name)

Discipline: ________________________ Specialty (if applicable): ________________________

Directions: Applicants are to certify by initialing each statement below that is applicable to them and that the statement is true.

____ ***Physicians***: I certify that I am certified in a primary care specialty from a specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association or completed a residency program in a primary care specialty that is approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association and have a current, full, permanent and unencumbered health professional license from the State in which I intend to practice as a NHSC LRP.

____ ***Primary Care Physicians Assistants***: I certify that I have a certificate of completion or an associate, bachelor's or master's degree from a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant at a college, university or educational institution that is accredited by a U.S. Department of Education nationally recognized regional or State institutional accrediting agency, National certification by the National Commission on Certification of Physician Assistants, and have a current full, permanent, unencumbered, health professional license, certificate, or registration in the State in which I intend to practice as a NHSC LRP.

____ ***Nurse Practitioners:*** I certify that I have a master's degree or post-master's certificate, or doctoral degree from a school accredited by the National League for Nursing Accrediting Commission or the Collegiate Nursing Education, and am certified by the American Nurses Credentialing Center, the American Academy of Nurse Practitioners, the Pediatric Nursing Certification Board, or the National Certification Corporation, and have a current full, permanent, unencumbered, health professional license, certificate, or registration in the State in which I intend to practice as a NHSC LRP.

_____ ***Certified Nurse-Midwives***: I certify that I have a master's degree or post-baccalaureate certificate from a school accredited by the American College of Nurse-Midwives, and am certified by the American Midwifery Certification Board, and have a current full, permanent, unencumbered, health professional license, certificate, or registration in the State in which I intend to practice as a NHSC LRP.

_____ ***Dentists***: I certify that I have completed a D.D.S. or D.M.D from a program that is accredited by the ADA and CODA, and have a current full, permanent, unencumbered, health professional license, certificate, or registration in the State in which I intend to practice as a NHSC LRP.

_____ ***Pediatric Dentists***: : I certify that I have completed a D.D.S. or D.M.D from a program that is accredited by the ADA and CODA, and have completed a 2-year training program in the specialty of pediatric dentistry that is accredited by the ADA and CODA, and have a current full, permanent, unencumbered, health professional license, certificate, or registration in the State in which I intend to practice as a NHSC LRP.

_____ ***Registered Dental Hygienists (RDHs)***: I certify that I have a bachelor's degree in dental hygiene or graduated from a 2-year dental hygiene training program accredited by the ADA and CODA, and have a least one year of experience as a licensed dental hygienist, and have successfully passed the National Board Dental Hygiene Examination, and have a current full, permanent, unencumbered, health professional license, certificate, or registration in the State in which I intend to practice as a NHSC LRP.

_____ ***Health Service Psychologists (HSP)***: I certify that I have a doctoral degree directly related to clinical or counseling psychology from a school accredited by the APA and COA, completed a minimum of one year of post-graduate supervised clinical experience, successfully passed the Examination for Professional Practice of Psychology, can practice independently and unsupervised as an HSP, and have a current full, permanent, unencumbered, health professional license, certificate, or registration in the State in which I intend to practice as a NHSC LRP.

_____ ***Licensed Clinical Social Workers***: I certify that I have a master's or doctoral degree in social work from a school accredited by the Council on Social Work Education, and successfully passed the Association of Social Work Boards (ASWB) Clinical or Advanced Generalist licensing exam *prior to July 1, 1998*, or the ASWB Clinical licensing exam *on or after July 1, 1998*, can practice independently and unsupervised, and have a current full, permanent, unencumbered, health professional license, certificate, or registration in the State in which I intend to practice as a NHSC LRP.

_____ ***Psychiatric Nurse Specialists who have a master's degree or higher in nursing from a program accredited by the NLNAC or CCNE with a specialization in psychiatric/mental health but are not certified as a clinical specialis***t, and 2-years of post-graduate supervised clinical experience, or have a bachelor's or higher in nursing from a program accredited by NLNAC or CCNE, and certified as a Psychiatric and Mental Health Nurse, Clinical Specialist in Adult and Mental Health Nursing, or Clinical Specialist in Child and Adolescent Psychiatric, and Mental Health Nursing and, have a current full, permanent, unencumbered, health professional license, certificate, or registration in the State in which I intend to practice as a NHSC LRP.

_____ ***Marriage & Family Therapists (MFTs***): I certify that I have a master's or doctoral degree in marriage and family therapy from a program accredited by the AAMFT, COAMFTE or have a graduate degree in another mental health field and completed a COAMFTE accredited post-graduate degree clinical training program in marriage and family therapy, and have at least 2-years of post-graduate supervised clinical experience in practice as a marital and family therapist or am a clinical member of the AAMFT , and have a current full, permanent, unencumbered, health professional license, certificate, or registration in the State in which I intend to practice as a NHSC LRP and can practice independently and unsupervised as an MFT.

_____ ***MFTs Without a Liscense:*** I certify that licensure as an MFT is not available in the State in which I intend to practice under the NHSC LRP, and that I have a current, full, permanent, unencumbered, unrestricted health professional license, certificate or registration (whichever is applicable) to practice independently and unsupervised as a MFT in a State.

_____ ***Licensed Professional Counselors (LPCs***): I certify that I have a master's degree or higher regarding counseling from a school accredited by the U.S. Department of Education nationally recognized regional or State institutional accrediting agency, and have at least 2-years of post-graduate supervised counseling experience, and am certified as a National Certified Counselor or a Certified Clinical Mental Health Counselor by the National Board for Certified Counselors, and have a current full, permanent, unencumbered, health professional license, certificate, or registration in the State in which I intend to practice as a NHSC LRP and can practice independently and unsupervised as a LPC.
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_____ ***LPCs***: I certify that licensure as an LPC is not available in the State in which I intend to practice under the NHSC LRP, and that I have a current, full, permanent, unencumbered, unrestricted health professional license, certificate or registration (whichever is applicable) to practice independently and unsupervised as an LPC in a State.

_____ ***Providers of Geriatrics Services***: I certify that I have completed discipline-specific advanced training in geriatrics (residency, fellowship, certification, etc.).

_____ ***Reservists***: I certify that I am a member of a Reserve Component of the Armed Forces or National Guard.

I hereby certify that the statements initialed above are true, complete and accurate to the best of my knowledge and belief and do not omit any material fact. I understand that the information given may be investigated and that any knowingly or willfully false representation, or concealment, of a material fact is sufficient cause for rejection of this application, or if awarded loan repayment, that I am liable for the return of all awarded funds and, further, that any such false statement or concealment may be punished as a felony under 18 U.S.C. 1001 and subject me to civil penalties under the Program Fraud Civil Penalties Act of 1986.

______________________________ ______________
Applicant Signature Date