Public Burden Statement: The purpose of this information collection is to obtain information through the National Health Service Corps (NHSC) Loan Repayment Program (LRP), NHSC Substance Use Disorder (SUD) Workforce LRP, and the NHSC Rural Community LRP applications, which are used to assess an LRP applicant's eligibility and qualifications for the LRP and to obtain information for NHSC site applicants. Clinicians interested in participating in a NHSC LRP must submit an application to the NHSC to participate in one of the NHSC programs, and health care facilities must submit an NHSC Site Application and Site Recertification Application to determine the eligibility of sites to participate in the NHSC as an approved service site. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0127 and it is valid until XX/XX/202X. This information collection is required to obtain or retain a benefit (Section 333 [254f] (a)(1) of the Public Health Service Act). Public reporting burden for this collection of information is estimated to average 0.5 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.

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
PRIVACY ACT RELEASE AUTHORIZATION

I, _____, residing at _____
_____, am an applicant/participant to the National Health Service Corps (NHSC) Loan Repayment Program (42 U.S.C. 254l-1). I hereby authorize the Department of Health and Human Services, and/or its contractors, to disclose any information contained in its files relating to my application to participate in the NHSC Loan Repayment Program **to:**

_____ _____
(Individual) **(Relationship/Name of Firm)**

_____
(Address)

_____
(City, State, Zip Code)

This authority shall remain in effect until **September 30, 2017**, or until this authorization is revoked by me in writing, whichever occurs first.

I certify that I am the above-named applicant. I understand that the knowing and willful request for, or acquisition of, information pertaining to an individual from an agency under false pretenses is a criminal offense under the Privacy Act, subject to a $5,000 fine (5 U.S.C. 552a(i)(3)).

_____ _____
(Signature of Applicant/Participant) **(Date)**

I certify that I am the above-named individual, to whom the applicant has authorized disclosure. I understand that the knowing and willful request for, or acquisition of, information pertaining to an individual from an agency under false pretenses is a criminal offense under the Privacy Act, subject to a $5,000 fine (5 U.S.C. 552a(i)(3)).

_____ _____
(Signature of Individual) **(Date)**