Faculty Loan Repayment Program

Fiscal Year 202x

Supplemental Form

Authorization to Release

To apply to the Faculty Loan Repayment Program, you must submit your online application, forms, and supporting documents to . **Applications that are mailed or faxed will not be accepted.**

Please note that several supporting documents will need to be completed online as part of the FLRP online application. Additional forms that must be uploaded (in a PDF format) and require an applicant's signature, are included in this Supplemental Forms package.

Questions? Call 1-800-221-9393 (TTY: 1-877-897-9910) Monday through Friday (except Federal holidays) from 8:00AM to 8:00PM,

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OMB No. 0915-0150 Expiration: TBD

Public Burden Statement

The purpose of this information collection is to obtain information through the Faculty Loan Repayment Program (FLRP), which is used to assess an applicant's eligibility and qualifications for the FLRP. 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 0915-0150 and it is valid until xx/xx/202x. This information collection is required to obtain or retain a benefit (Section 738(a) of the Public Health Service Act (42 USC 293b (a)). Any datasets made available to the public with regards to the Faculty Loan Repayment Program (42 U.S.C. 293b(a) (Sec. 738(a) of the PHS Act), would be de-identified, limited to information the disclosure of which would not constitute a clearly unwarranted invasion of personal privacy under the Freedom of Information Act and the Privacy Act. A Privacy Act Notification Statement is included on the FLRP website which describes the purpose of the information collection and the potential disclosures. A Privacy Act System of Records, #09–15–0037, have been established for the FLRP, HHS/HRSA/BHW. Public reporting burden or this collection of information is estimated to average xx 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 Information Collection Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, Maryland, 20857 or paperwork@hrsa.gov.

FACULTY LOAN REPAYMENT PROGRAM
AUTHORIZATION to RELEASE
INFORMATION

As a Faculty Loan Repayment Program applicant/participant, I_____, hereby authorize:

i. The Health & Human Services Secretary, and/or its contractors, to release the following information to the lenders/holders of my educational loans in order to determine my eligibility/qualifications to participate in the Faculty Loan Repayment Program, and to determine the eligibility of my educational loans for repayment under the Faculty Loan Repayment Program: my name, address(es), social security number, account number(s), account status, and other information necessary to identify me.

ii. The Health & Human Services Secretary, and/or its contractors, to release my name, address(es) and social security number for the purpose of determining whether I appear on the Do Not Pay List.

iii. Any program to which I owe a health professions service obligation to release information relating to that obligation to the Health & Human Services Secretary and/or its contractors.

iv. The Health & Human Services Secretary, and/or its contractors, to release the following information to the educational institution where I am/will be employed as a faculty member to assess my eligibility to participate in the Faculty Loan Repayment Program, and, if selected to participate in the Faculty Loan Repayment Program, my compliance with the Faculty Loan Repayment Program service obligation: name, social security number and other identifying information.

v. The educational institution at which I am/will be employed as a faculty member to release information relating to my employment status (e.g., date of employment, number of hours worked, absences from work, position held, etc.) to Health & Human Services Secretary and/or its contractors, for purposes of determining my eligibility to participate in the Faculty Loan Repayment Program and, if I am selected to participate in the Faculty Loan Repayment Program, my compliance with the Faculty Loan Repayment Program service requirements.

This authorization will take effect on the date I sign this release. If I am a participant in the Faculty Loan Repayment Program, this authorization shall remain in effect until the date my Faculty Loan Repayment Program obligation has been fulfilled. If I do not become a participant in the Faculty Loan Repayment Program, this authorization shall remain in effect until ***September 30th*** of the fiscal year in which it was signed or until this authorization is revoked by me in writing, whichever occurs first.

Signature of Applicant Date