OMB No: 0906-0082
Expiration Date: xx/xx/xxxx
Bureau of Health Workforce
U.S. Department of Health and Human Services
Health Resources and Services Administration

Faculty Loan Repayment Program
Institution/Employment Loan Repayment Form
(To be Completed By Institution)

Section 1 - Institution Information

Name of Institution

School of (e.g., medicine, nursing, allied health)

The institution is accredited by

Profit status (select one)

- ☐ Private non-profit
- ☐ Public/government owned
- ☐ Private for-profit

Optional: The institution is (select all that apply):

- ☐ Historically Black
- ☐ Hispanic Serving
- ☐ Tribal

Optional: The institution is located in a (select all that apply):

- ☐ Medically Underserved Area
- ☐ Health Professional Shortage Area

Section 2 - Applicant Employment Information

Applicant name

(Select one) ☐ Full Time ☐ Part Time

(Select one) ☐ Tenured ☐ Non-Tenured

Teaching discipline

Number of hours/week

Initial Employment start date

Fall term start date

Number of months in an academic year

Number of months in an academic year that applicant serves as faculty

This institution intends to employ the applicant indicated above for a minimum of 2 years after the application close date (select one):
To be eligible for the Faculty Loan repayment Program, applicants must have an employment commitment from an eligible health professions school for a faculty position for a minimum of two years.

Section 3 -Institutional Match Agreement

Regardless of selection below, the school must provide a letter detailing their award match agreement or waiver request and supporting documentation of undue financial hardship. Details of the award match requirement are found in the Application and Program Guidance.
The institution (select one from below):

☐ **Full match**
The institution 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 payments(s) made by the Health & Human Services 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 Health & Human Services/Faculty Loan Repayment Program

☐ **Partial match**
Match amount from institution:
The institution is able to make payments of principal and interest on the educational loans of the applicant in the amount less than the amount of such payment(s) made by the Health & Human Services Secretary (maximum $40,000 total for 2-year period) and requests a partial waiver, on the basis of undue financial hardship, of the requirement that it fully match the Health & Human Services Secretary's payment(s).

☐ **Full waiver**
The institution is unable to make any payments of principal and interest on the educational loans of the applicant and requests a full waiver, on the basis of undue financial hardship, of the requirement that the institution make loan repayments equal to the amount of such payment(s) made by the Health & Human Services Secretary.

OMB No: 0906-0082
Expiration Date: xx/xx/xxxx
Bureau of Health Workforce
U.S. Department of Health and Human Services Health Resources and Services Administration

**Institutions that fail to comply with their specific match agreement indicated above will be held liable for default, and all future applicants employed at their institution will be deemed ineligible for the Faculty Loan Repayment Program.*

Please submit this form, the match letter/waiver, and the supporting documentation to the applicant for submission with their application.

Institution Official's Name **Title** **Signature**

Date **Mailing Address** **Phone/Fax/Email**

For questions on how/where to submit this form please contact the Customer Care Center at: 1-800-221-9393.

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 0906-0082 and it is valid until xx/xx/xxxx. This information collection is required to obtain or retain a benefit (Section 738(a) of the Public Health Service Act (42 USC 293b (a)). The information is protected by the Privacy Act, but it may be disclosed outside the U.S. Department of Health and Human Services, as permitted by the Privacy Act and Freedom of Information Act, to Congress, the National Archives, and the Government Accountability Office, and pursuant to court order and various routine uses as described in the System of Record Notice 09-15-0037. 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 13N82, Rockville, Maryland, 20857.