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

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 the Faculty Loan Repayment Webpage.
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, ET.

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.

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AUTHORIZATION TO RELEASE INFORMATION FORM

As a Faculty Loan Repayment applicant/participant, I : _____ hereby authorize:

(Print Name - Last, First, Middle Initial)

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 the Applicant: **Date:**