

**STATE LOAN REPAYMENT PROGRAM (SLRP)  
PART II**

**APPLICATION DEADLINE: October 15, 2014**

**PART II: PRACTICE SITE CONFIRMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize my employer, \_\_\_\_\_, to provide the information requested by the Maryland Higher Education Commission, Office of Student Financial Assistance.

Candidate's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY YOUR EMPLOYER**

Practitioner is an (check one): \_\_\_\_\_ MD/DO or \_\_\_\_\_ Physician Assistant

Practice Specialty: \_\_\_\_\_ Date Employment Began: \_\_\_\_\_ Annual Salary: \_\_\_\_\_

1. Will the practitioner work at least 40 hours (full-time) per week, excluding time spent "on call?"  Yes  No

If **No**, please explain: \_\_\_\_\_

2. Will the practitioner provide at least 32 of the 40 normally scheduled office hours per week in an ambulatory (outpatient) setting?

Yes  No If **No**, please explain: \_\_\_\_\_

3. Will the practitioner's 40-hour work week be compressed into less than 4 days per week or with shifts of more than 12 hours in any 24-hour period?

Yes  No If **Yes**, please explain: \_\_\_\_\_

4. Has/Will the practitioner spent/spend more than 7 weeks (35 days) away from the practice for holidays, vacation, continuing professional education, illness or any other reason during a 52-week time period?

Yes  No If **Yes**, please explain: \_\_\_\_\_

I certify that the information provided above is true and correct.

\_\_\_\_\_  
Printed name of person completing this form

\_\_\_\_\_  
Signature of person completing this form

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**PLEASE MAIL TO:**

Temi Oshiyoye, Workforce Coordinator, Attn: SLRP Application  
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