

# Mental Health Loan Assumption Program

Information Update

## Instructions

Within thirty (30) days of making changes to your employment, personal information or educational debt, please submit this report to: Health Professions Education Foundation, ATTN: MHLAP, 400 R Street, Room 460, Sacramento, CA 95811.

**Please complete this form if any of the following items have recently changed or will change in the next 30 days:**

- Legal Name
- Mailing Address
- Phone Number
- Educational Lender/ Loan Servicing Agency
- License or Registration Number
- Employer
- Employer Address
- Work Schedule

**Has any of the above information changed?** (Please circle one) **Yes** **No**

**If "yes" please specify below and provide a brief explanation:**

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## Awardee Certification

I understand that falsification of any information on this form breaches the terms of my contract. I verify that the above information is true and accurate.

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Contract Number:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Failure to notify the Foundation within 30 days of changing your personal, educational debt, or work information may jeopardize the status of your award as you will breach of the terms of your contract.