STEVEN M. THOMPSON PHYSICIAN CORPS LOAN REPAYMENT PROGRAM

CERTIFICATION OF PRACTICE SETTING

This page must be completed and uploaded on www.calreach.oshpd.ca.gov for your application to be considered complete. This form must be completed by the administrative officer or your direct supervisor employed at the practice setting listed below. If the applicant works at more than one site, please fill out and upload additional forms and indicate the number of hours per week to be provided at each site.

Applicant Name: _____

Applicant's Employer Name: _____

Street Address (where the applicant will physically work): _____

City:_____State: _____ Zip: _____ County: _____

Start Date:_____/_____/_____ ❑F/T or ❑P/T Average No. of hours per week at this site: _____

Average No. of hours per week of direct patient care: _____

Applicant's Specialty:

Family Physician	General Internist	General Pediatrician
General Psychiatrist	Gerontologist	Obstetrician/Gynecologist

Other(s):_____

1. The applicant can speak the following Medi-Cal threshold language(s):

Arabic	Hmong	Mandarin	Tagalog
Armenian	Khmer	Other Chinese	Vietnamese
Cantonese	Korean	Russian	Not Applicable
Farsi	Laotian	Spanish	

2. At least 50 percent of the patients at this practice site are from the Medi-Cal Program and/or uninsured populations. YES NO

3. The facility is a geriatric care setting or the applicant works in a setting that primarily serves adults over the age of 65 years or adults with disabilities. YES NO

By signing this form below, I certify that the practice setting will pay the applicant prevailing wages and I agree not to use the program's award of educational loan repayments as a means to reduce the recipient's salary or offset those salaries (e.g., deduction of funds from paychecks, etc.). I am the administrative officer at this facility and I declare under penalty of perjury that the statements above are true and correct.

Supervisor or Administrative Officer Name: (Please Print) _____

Title: _____

Phone/Ext:_____X_____ Fax: _____

Email: _____

Signature:_____ Date: _____

Don't forget Supervisor or Administrative Officer's signature and date! Applicants: upload this form and type the information provided above at www.calreach.oshpd.ca.gov