

**IOWA OSTEOPATHIC FORGIVABLE LOAN PROGRAM
2010-2011
MEDICAL PRACTICE CONFIRMATION FORM**

PURPOSE: Recipients of an Iowa Osteopathic Forgivable Loan must practice, full time, in the State of Iowa for two years or repay the loan plus accrued interest. In order to document eligible years of practice, this form must be completed and submitted annually, along with a copy of a current State of Iowa medical license.

In order to receive credit toward your obligation, complete and mail this form, and the required proof of medical license, to:

Iowa Osteopathic Forgivable Loan Program
Iowa College Student Aid Commission
603 E 12th Street, FL 5th
Des Moines, IA 50319

PART I -- To Be Completed by Loan Recipient

A. I certify that I am practicing full-time as a licensed physician in the state of Iowa. I have enclosed a copy of my State of Iowa medical license and State of Iowa medical license renewal certification, if applicable.

I understand that if I fail to complete the practice obligation of the Iowa Osteopathic Forgivable Loan Program, I must repay the remaining unpaid balance of my forgivable loans prorated by the number of months that I have practiced in Iowa.

Signature _____ Date _____

B. Recipient Information

Start Date of Iowa Practice _____

Name _____ Last 4 digits of SSN _____

Mailing Address _____

City _____ State _____ ZIP _____

Day Time Phone _____ E-mail Address _____

C. Employment Information

Medical Organization/Clinic Name _____

Business Address _____

City _____ State _____ ZIP _____

PART II -- To Be Completed by Verifying Official

D. I certify that the information stated above is correct. The listed doctor is working full-time, as defined by the listed medical organization/clinic.

Signature _____ Title _____
(Verifying Employer Official)

Name _____ Date _____
(Please type or print)