Minnesota State Loan Repayment Program
Site Notification and Verification (FT)

I,

_____ (print name of authorized site representative),

understand that

_____ (clinician) has accepted an award through the
Minnesota State Loan Repayment Program (SLRP) and has signed a two-year service agreement with the
State.

The service agreement under this program obligates the provider to a number of terms including, but
not limited to, the requirements listed below.

SLRP participants must be employed a minimum of 40 hours per week, of which 32 hours must be
providing patient primary care at the approved outpatient clinical site(s). Additionally, participants must
be onsite at least 45 weeks per year. Emergency Room, "on call" coverage and care provided off-site are
not considered eligible service to meet the minimum hourly requirement for patient care for this
program. As an exception, OB/GYN physicians, family medicine physicians who practice obstetrics on a
regular basis, certified nurse midwives and providers of geriatric services may provide up to 11 hours of
the 32 minimum patient care hours in other settings as directed by the approved site.

Participants must use loan repayment disbursements from this program to pay designated educational
loans. Payments must be made to the designated loans within 30 days of receipt of funds AND proof of
payment submitted to the Minnesota Department of Health program contact within 60 days.

Participants must submit a Confirmation of Practice form at the start of his or her obligation, annually,
and as requested by the State. This confirmation form must be signed by the participant and by an
authorized representative of the participant's approved clinical site.

Participants may NOT complete any other service obligation (local, state or federal) while completing
the SLRP obligation.

Participants failing to complete the service obligation and/or fully comply with the terms of the
agreement will be responsible for serious financial penalties.

**Sites that fail to provide employment conditions that satisfy the obligations of the SLRP participant
may not be considered for future participation in this program.**

As the authorized site representative, I agree to support _____ (clinician) in
successfully completing the service obligation and terms set forth by the SLRP agreement with the state.

_____   _____

Signature of Authorized Representative   **Date**

_____

Title of Authorized Representative