DC Department of Health
Primary Care Bureau
Health Professional Loan Repayment Program
899 North Capitol Street NE, 3rd Floor
Washington, DC 20002
P: (202) 442-9168 F: 202.442.4948 EMAIL: HPLRP@dc.gov

DC HEALTH PROFESSIONAL LOAN REPAYMENT PROGRAM APPLICATION

Section III: Loan and Lender Information *(This is the third of three sections that make up the DC HPLRP Application.)*

Part A: Applicant Information *(To be completed by Applicant)*

First Name: _____ MI: _____ Last Name: _____

Email: _____

Complete Part A of Section III: Loan and Lender Information, then save and send to your lender(s).

An application cannot be processed until Section III: Part B (or comparable information) from the lender(s) is received by the Primary Care Bureau.

You are responsible for contacting your lender(s) to assure that the information below is sent and received.

If your educational loans have been sold to another lender, or consolidated by a loan marketing association, submit the request for loan information to the new lender.

Part B: Loan Data and Certification *(to be completed by lender)*
The applicant named above is applying for a contract to repay educational loans through the District of Columbia Health Professional Loan Repayment Program (HPLRP).

Please complete Part B of Section III: Loan and Lender Information and click "Submit" or fax to 202.442.4948 or email to HPLRP@dc.gov any documentation that verifies the applicant's loan information, the total unpaid principal balance, outstanding interest, the disbursement date, and the loan type for each loan held by the lender. Although the lender is not required to submit the loan information using the form below, the lender must sign and submit the Lender's Certification on page 2.

Please provide the HPLRP with the information requested below.

1. Original Amount of Loan: $_____

2. Current Principal Balance: $_____ Date of this Balance: _____

3. Current Amount of Outstanding Interest: $_____

If other than outstanding interest, please explain:

_____

_____

_____

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4. Disbursement Date and Type of Loan:

Disbursement Date		Type of Loan (e.g. Subsidized Stafford)		Amount for Each Loan That You Service	
Date		**Type**		**Amount**	
Date		**Type**		**Amount**	
Date		**Type**		**Amount**	
Date		**Type**		**Amount**	
Date		**Type**		**Amount**	
Date		**Type**		**Amount**	
Date		**Type**		**Amount**	

Is/are any of the loan(s) listed above in default? ◯ Yes ◯ No

Lender's Certification

The undersigned states that, to the best of his/her knowledge, the loan(s) identified in this section is/are bona fide, legally-enforceable loan(s) made for the purpose of meeting the borrower's cost of attending a school or institution where he/she obtained clinical training.

Name of Lending Institution: _____
(Please Print)

Complete Address of Lending Institution: _____
(Number) (Street) (Suite Number)

_____
(City) (State/Province) (Country) (Zip Code)

Telephone Number: _____ Fax Number: _____

Name/Title of Officer: _____
(Please Print)

Signature: _____ Date: _____
(Authorized Official or Lender)

SUBMIT FORM ELECTRONICALLY TO: hplrp@dc.gov
Or Fax: 202.442.4948
Or mail to:
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Primary Care Bureau
899 North Capitol Street NE,
3rd Floor
Washington, DC 20002

Save As Submit Form