Community Match Rural Physician Recruitment Program
Community Application – 2011

Please PRINT or write legibly. Use black ink. Return this application to the Rural Practice Program Administrator by **February 28, 2011** along with the Community Designee Form. In order for this to be accepted, your Community Match physician must submit the Physician Application by **February 28, 2011**.

City and County: _____________________________                      Date: __________________

Population as of last federal census: ______________________________

Name of physician: _________________________________________

What type of Primary Care Medicine would your physician plan to practice full time in your community? (Primary Care for purposes of this program is defined as: Family Medicine, General Internal Medicine, General Internal Medicine and Pediatrics, General Pediatrics, General Obstetrics and Gynecology, General Surgery, and Emergency Medicine)

You may request a specialty other than those listed above. Preference will be given to those planning to practice Primary Care.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Number of physicians currently practicing this Primary Care specialty in or near your community:

____________________________________________________________________
____________________________________________________________________

Is your community a federally designated **Medically Underserved Area** and/or a **Health Professional Shortage Area**? If yes; is it the city, county or particular clinic in which the physician would be practicing?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

____________________________________________________________________
Attach additional information regarding your community’s need for this physician. If you are requesting a specialty other than Primary Care, please give specific reasons for doing so. Try to include as much of the following information as possible:

- The ratio of primary care physicians to the population
- The infant mortality rate
- Percentage of the population with income below the federal poverty level
- Percentage of population over age 60
- Percentage of physicians over age 60
- Level of accessibility to primary care in the area
- Other information you would like the Board to consider

CERTIFICATION AND SIGNATURE:

I understand that the information submitted by me on this application will be used to assist the Arkansas Rural Medical Practice Student Loan and Scholarship Board in determining my community’s eligibility for the Community Match Loan and Rural Physician Recruitment Program. I also understand that the number of accepted applicants is also based on the amount of available funds.

SIGNATURE of Mayor or Community Designee       TITLE       DATE

Complete and return this form to Rural Practice Program Administrator, 4301 West Markham, #709-1, Little Rock, AR 72205.
Community Match Loan and Rural Physician Recruitment Program

COMMUNITY DESIGNEE FORM

COMMUNITY DESIGNEE: This individual serves as the “contact person” for mailings, correspondence, etc. for the community and is the individual authorized by the community to obligate funds, disburse checks, and sign the Community Match contract. The Community Designee is the Mayor of the contracting community unless he/she designates someone else (see the section below) to serve in this capacity, i.e., hospital administrator, etc.

NAME: ________________________________ DATE: ____________________

TITLE: _____________________________________________________________

Position / Organization / Entity

MAILING ADDRESS: ________________________________________________

________________________________________________________________________

City           State                Zip code

PHONE: ________________ FAX: _______________ EMAIL: _______________

If the COMMUNITY DESIGNEE is someone other than the Mayor of the city listed above, this form requires the signature of the Mayor, certifying that the community has authorized the individual listed above as its COMMUNITY DESIGNEE.

SIGNATURE OF MAYOR (required): ______________________________________________

PRINTED NAME AND TITLE (If different from above):

________________________________________________________________________________

Please have this Community Designee Form Notarized.

________________________________   My term expires: __________________           Seal

Complete and return this form to Rural Practice Programs Administrator, 4301 West Markham, # 709-1, Little Rock, Arkansas, 72205.