



# Community Match Loan and Rural Physician Recruitment Program Physician Application – 2010

Please PRINT or write legibly. Use black ink. Return this application to the Rural Practice Program Administrator by **February 28, 2010**. In order for this to be accepted, your community must submit the Community Application by **February 28, 2010**.

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**Note if you participated or are participating in the Rural Practice Scholarship and Loan Program or the Community Match Student Loan and Scholarship Program, you are ineligible to participate in this program.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone number: \_\_\_\_\_ E-mail: \_\_\_\_\_

Current Address:

\_\_\_\_\_  
\_\_\_\_\_

Requested Contract Community and Community Designee:

\_\_\_\_\_

What type of Primary Care Medicine would you plan to practice full time in this 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.

\_\_\_\_\_  
\_\_\_\_\_

To be eligible, you must have graduated from an accredited medical school in the United States. List the medical school you attended and graduation date:

\_\_\_\_\_  
\_\_\_\_\_

To be eligible, you must currently be in a residency training program or have completed a residency training program no more than two years prior to the date of application. List your residency training program(s) and date of completion or expected completion:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Will you or have you received any other funding from another state, federal, or scholarship program for practicing in this rural community? If yes, what program and what was the amount? (This includes any other service connected scholarships/loans/grants)

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Do you have any other obligations or commitments that would prevent you from completing four years of service in this rural community?

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What considerations led to your decision to practice primary care medicine in this rural community? Have you ever lived in this community or another rural community in Arkansas?

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To what extent have you been exposed to and/or involved in the practice of medicine in a rural setting?

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**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 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

\_\_\_\_\_  
DATE

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