



72 East Concord Street, A-401
Boston, Massachusetts 02118-2526
T 617-638-5130 F 617-638-5116
Toll Free 1-877-776-6243

CERTIFICATION OF PRIMARY CARE TRAINING OR PRACTICE

As a recipient of funds from the BUMC Primary Care Pool, you agreed to certify annually that you are either training in or practicing primary health care according to the terms of your scholarship or loan agreement. PLEASE NOTE: Returning this form promptly is very important! Recipients of **federal funds** who do not return it by the deadline referenced below are subject to *severe* financial penalties, even if they are complying with all other aspects of the obligation.

If you have any questions or concerns, please contact the Office of Student Financial Services at (617) 638-5130 or 1-877-776-6243 or osfs-med@bu.edu.

This form is also posted on the Office of Student Financial Services website, www.bumc.bu.edu/osfs/webforms, and can be submitted on-line.

CURRENT ADDRESSES AND TELEPHONE NUMBERS:

Name _____	Work Address _____
Home Address _____	_____
_____	_____
Home Phone _____	Work Phone _____
Beeper # _____	E-mail _____

RESIDENCY TRAINING ACTIVITIES:

I am/was enrolled in a residency training program in the following discipline:

- | | |
|--|--|
| <input type="checkbox"/> General Internal Medicine | <input type="checkbox"/> Preventive Medicine |
| <input type="checkbox"/> General Pediatrics | <input type="checkbox"/> General Dentistry |
| <input type="checkbox"/> Family Medicine | <input type="checkbox"/> Other (please explain below or on back) |

Name of Program _____

Begin Date (month/year) _____ (Projected) End Date (month/year) _____

Comments: _____

PRACTICE ACTIVITIES:

I am currently practicing primary health care in the following discipline:

- | | |
|--|--|
| <input type="checkbox"/> General Internal Medicine | <input type="checkbox"/> Preventive Medicine |
| <input type="checkbox"/> General Pediatrics | <input type="checkbox"/> General Dentistry |
| <input type="checkbox"/> Family Medicine | <input type="checkbox"/> Other (please explain below or on back) |

Begin Date (month/year)_____

Comments:_____

CERTIFICATION:

I certify that the information contained on this form is accurate and that I am in compliance with the primary care training and practice obligations specified in my agreement for the scholarship and/or loan program(s) identified below.

SIGNATURE

DATE

PLEASE COMPLETE AND RETURN THIS FORM if you received funds while a student at Boston University Medical Campus from the following sources:

- Exceptional Financial Need (EFN) Scholarship
- Financial Assistance for Disadvantaged Health Professions Students (FADHPS) Scholarship
- Federal Primary Care Loan (PCL)
- John I. Sandson Primary Care Loan
- John and Hannah Sandson Primary Care Loan
- Ruth M. Batson Primary Care Loan
- Robert Wood Johnson Foundation Loan

PLEASE RETURN THIS COMPLETED FORM TO:

**BOSTON UNIVERSITY MEDICAL CAMPUS
OFFICE OF STUDENT FINANCIAL SERVICES
72 EAST CONCORD STREET, ROOM A401
BOSTON, MA 02118-2526
PHONE: (617) 638-6417
FAX: (617) 638-5116
E-MAIL: osfs-med@bu.edu
WEB SITE: www.bumc.bu.edu/osfs/webforms**

PRIMARY CARE ASSISTANCE