BOSTON UNIVERSITY MEDICAL CAMPUS

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 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 Joseph F. Corbett, Project Manager at the BUMC Office of Student Financial Services at (617) 638-6417 or corbettj@bu.edu.

This form is also posted on the Office of Student Financial Services web site and can be submitted electronically. It is accessible by going to www.bumc.bu.edu/osfs, clicking on "School of Medicine," clicking on "Websites and Forms," scrolling to the bottom and clicking on "Certification of Primary Care Training or Practice."

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:

☐ General Internal Medicine ☐ Preventive Medicine

☐ General Pediatrics ☐ General Dentistry

☐ Family Medicine ☐ Other (please explain below or on back)

Name of Program _____

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

Comments: _____

_____

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PRACTICE ACTIVITIES:

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

- ☐ General Internal Medicine
- ☐ General Pediatrics
- ☐ Family Medicine
- ☐ Preventive Medicine
- ☐ General Dentistry
- ☐ 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.

PRINT THE FORM, SIGN AND DATE AREAS WHERE APPROPRIATE

HIT THIS BUTTON TO CLEAR ALL DATA!

_____ SIGNATURE

_____ DATE

This form should be completed 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
715 ALBANY STREET, A-401
BOSTON, MA 02118-2526
PHONE: (617) 638-6417
FAX: (617) 638-5116
E-MAIL: corbettj@bu.edu
WEB SITE: www.bumc.bu.edu/osfs