OREGON HEALTH & SCIENCE UNIVERSITY

SEND COMPLETED FORM TO:

Oregon Health Science University (83)
c/o Heartland ECSI
P.O. Box 1289
Moon Township, PA 15108
1-888-549-3274

REQUEST FOR PARTIAL CANCELLATION
NURSE FACULTY LOAN PROGRAM

INSTRUCTIONS: A borrower under the Nurse Faculty Loan Program must file this form with the school of nursing which made the loan in order to claim entitlement to loan cancellation for full-time nurse faculty employment pursuant to Section 846A of the Public Health Service Act, as amended by Public Law 107-205. The form must be submitted for each complete year of full-time nurse faculty employment in a school of nursing. It is the responsibility of the borrower seeking cancellation to (a) complete Part 1, (b) obtain certification by the employing agency, Part 2 and (c) forward the original and one copy to the lending school for cancellation of the loan at the appropriate rate in lieu of payment. The lending school will complete Part 3, indicating the amount of cancellation earned (principal and interest), and return the copy to the borrower making such request.

NAME & ADDRESS OF SCHOOL FROM WHICH LOAN WAS MADE: **OREGON HEALTH & SCIENCE UNIVERSITY** **STUDENT LOANS, L332** **3181 SW SAM JACKSON PARK ROAD** **PORTLAND, OR 97239-3098**	**NAME & ADDRESS OF THE APPLICANT**	
PART I – COMPLETED BY BORROWER		
I hereby apply for a partial cancellation of my Nurse Faculty Loan in the appropriate amount of principal and interest, in accordance with Sections 846A of the Public Health Service Act, as amended by Public Law 107-205, for one year of employment as a full-time nurse faculty.		
NAME AND ADDRESS OF EMPLOYING AGENCY	**PERIOD OF EMPLOYMENT:**	
	BEGINNING (Month, Day, Year)	**END (Month, Day, Year)**
	SIGNATURE OF APPLICANT	**DATE**
PART II – CERTIFICATION BY EMPLOYING AGENCY		
I hereby certify that the above statements concerning full-time/part-time nurse faculty or clinical educator/preceptor employment and the period of service are true and correct.		
NAME OF APPLICANT	**POSITION TITLE OF APPLICANT**	
NAME & ADDRESS OF EMPLOYING AGENCY	**SIGNATURE OF AUTHORIZED OFFICIAL**	
	TITLE	**DATE**
CHECK: ( ) PUBLIC ( ) Private for Profit ( ) Private not for Profit		
PART III – PARTIAL LOAN CANCELLATION (To be completed by Lending School)		
The above named individual's loan account has been credited for partial cancellation for full-time employment as nurse faculty in accordance with the Section 846A of the Public Health Service Act, as amended, in the following amounts:		
CANCELLATION RATE BY YEAR FOR EMPLOYMENT AS NURSE FACULTY:	**CANCELLED:**	
( ) 1st Year – 20% **( ) 2nd Year – 20%**	**PRINCIPAL AMOUNT**	**INTEREST AMOUNT**
( ) 3rd Year – 20% **( ) 4th Year – 25%**		
SIGNATURE OF AUTHORIZING OFFICIAL – LENDING SCHOOL	**TITLE**	DATE

NFLP EMPLOYMENT CERTIFCATION FORM

(Applicant's Name) _____ entered into a contractual agreement with Oregon Health and Science University as a participant in the Nurse Faculty Loan Program (NFLP). This program requires the borrower to be employed full-time/part-time as nurse faculty in an accredited school of nursing, or as a full-time/part-time clinical educator/preceptor at an accredited health facility, or as designation of nurse faculty in a joint nurse faculty appointment serving as full-time advanced practice registered nurse (APRN) preceptor for an accredited school of nursing, within an academic-practice partnership framework for a complete year in order to receive cancellation of his/her loan. Please complete the Certification Form.

Mail to: Oregon Health & Science University
Students Loans, Mailcode L332
3181 SW Sam Jackson Park Road
Portland, OR 97239-3098

Fax to: 503-346-6837

PART I: TO BE COMPLETED BY LOAN RECIPIENT

Name: _____

Permanent Address: _____ Phone # _____

_____

Place of Employment: _____

Address: _____

_____

Beginning Date of Employment as Nurse Faculty: Month _____ Day _____ Year _____

Position Title: _____

I **CERTIFY** that I am employed full-time as Nurse Faculty in the above named School of Nursing, and all the information is true and correct to the best of my knowledge. If I change employment status, I will notify Oregon Health & Science University immediately.

Signature: _____ Date: _____

PART II: TO BE COMPLETED BY EMPLOYER

I **CERTIFY** that the statements above concerning service of the above named NFLP loan recipient as a full-time nurse faculty are true and correct. Keep a copy for your records.

Name of Certifying Official: _____

Title: _____ Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

If the above-named participant has **not** maintained faculty/clinical educator/preceptor status during this period, please provide the date(s) and explanation for the change.

Date(s): _____

Explanation: _____

_____

WARNING: ANY PERSON WHO KNOWLINGLY MAKES A FALSE STATEMENT OR MISREPRESENTATION OF THIS FORM IS SUBJECT TO PENAL TIES WHICH MAY INCLUDE FINES AND IMPRISONMENT UNDER FEDERAL STATUTE.