UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL LEARNING CONTRACT
ANNUAL REQUEST FOR *POSTPONEMENT* OF REPAYMENT DUE TO SERVICE PAYBACK—*UNDER SERVED*

PART 1 - GENERAL INFORMATION (to be completed by borrower - please type or print)

NAME OF BORROWER _____

SOCIAL SECURITY NUMBER _____-_____-_____

NAME USED AT UMMS _____

CLASS YEAR or SEPARATION DATE FROM UMMS _____

STREET ADDRESS _____

HOME TELEPHONE NUMBER (_____)_____

CITY _____ STATE ZIP CODE

WORK TELEPHONE NUMBER (_____)_____

Email address: _____

PART 2 - POSTPONEMENT REQUEST INFORMATION

Because I expect to pay my learning contract with service, I request postponement of payment while I practice for 12 consecutive months within the Commonwealth of Massachusetts. I declare that I am currently engaged in the practice of health care in a manner consistent within my medical education & training as a physician, AND **I have attached a Job Description** (please see page 2 for details).

A. Requested postponement dates: from**:** _____**/**_____**/**_____ to**:** _____**/**_____**/**_____ ***A single form c****annot be certified for more than ONE (1 year in advance).*

B. I certify that I am/was engaged in the following practice of health care in a manner consistent within my medical education and training as a PHYSICIAN in:

1)_____ **UNDER SERVED (MUST BE PRE-APPROVED BY UMMS)**

*I must complete this form **annually** while I perform eligible employment (as specified in contract.) If I change jobs within the 12 months requested, I must complete another postponement form for the new site, and a cancellation form from your prior site. I also understand and agree that if for any reason I do not complete the entire period of service listed above, I will notify UMMS and begin monetary payments immediately. Please contact the Loan Manager for further instructions.*

SIGNATURE OF BORROWER **DATE**
➔

PART 3 - CERTIFICATION BY A THIRD PARTY AUTHORIZED BY SERVICE SITE (Program Director, Supervisor, Business Manager, or Equivalent)

NAME OF EMPLOYER _____

DEPARTMENT/PROGRAM _____

ADDRESS _____

CITY/STATE/ZIP _____

TELEPHONE NUMBER _____

DATE EMPLOYEE BEGAN PRACTICING MEDICINE AT CURRENT SITE: _____

TITLE OF EMPLOYEE POSITION: _____

EMPLOYEE FTE PERCENTAGE: _____

INDICATE THE NUMBER OF CLINICAL HOURS PER WEEK: _____

INDICATE THE NUMBER OF ADMINISTRATIVE HOURS PER WEEK: _____

IS THIS POSITION CONSIDERED A HOSPITALIST: **YES** _____ **NO** _____

I certify that the information for the person named above, including dates and service type are true and correct, and service was completed in Massachusetts.

_____

SIGNATURE AND TITLE **PRINTED NAME** **DATE**
➔ **(PROGRAM DIRECTOR, SUPERVISOR, BUSINESS MANAGER, or EQUIVALENT)**

DO NOT CERTIFY BEFORE START DATE

PART 4 -UMMS USE ONLY

	FROM	**TO**	**NO. MONTHS**	**CODE**
POSTPONEMENT PERIOD	_____/_____	_____/_____	_____	_____

FORMS PROCESSED BY: _____ DATE: _____ ECSI NOTIFIED DATE: _____

University of Massachusetts Medical School Learning Contract
Request for Postponement of Service Payment

INSTRUCTIONS

You may use this form to postpone the due date of payment on your Learning Contract if you are currently providing service that qualifies for payment.

* * ****THIS FORM MUST BE COMPLETED ON AN ANNUAL BASIS***.* * *

1. Complete Part 1: General Information

2. Complete Part 2: Requested postponement dates, and Service type. Sign, and date.

3. Complete Part 3: Have this certified by an authorized employer representative who clearly indicates his or her job title.

   -or-

   If you are self-employed, please provide documentation of hospital admitting privileges, or contact the Financial Aid Office for instructions.

4. Letter from the borrower explaining the underserved population he/she is servicing (a lot of times this is a letter to the committee of them asking to be considered for service payback, backed up with the population they are servicing).

5. Payer Mix

6. Return Completed, Signed and Certified form along with a **JOB DESCRIPTION*** to:

   Student Loan Manager
   Financial Aid Office
   UMASS Medical School
   55 Lake Ave. North
   Worcester, MA 01655

   *Job descriptions must include the following information on letterhead from your employer: date began practicing medicine at current site, FTE percentage, description of employment, and signature and title of authorized individual (human resources, business manager, supervisor or program director.)

7. If you change jobs within the 12 months requested, you must completed another postponement for the new site, and a cancellation form from your prior site. Please contact the Loan Manager for further instructions.

09/17 TMS