



MLRP APPLICATION PART II - Practice Site Confirmation

Maryland Loan Repayment Program

Application Deadline: May 1, 2024

Review and follow all application cycle instructions in order to meet submission requirements.

Application ID Number

(from notification email)

Applicant Name

First

Last

Applicant's Email Address

1. Applicant Profession

2. Applicant Specialty

3. Employment Start Date

4. Annual Salary (Current)

SAMPLE - NOT FOR SUBMISSION

5. Practice Site Type

- Academic institution (Higher education)
- Acute Care for the Elderly (ACE) Unit
- Certified Community Behavioral Health Center (CCBHC)
- Community Health Center (e.g. Free clinic)
- Day or Home Care Program (e.g. Home Health)
- Dental Office
- Emergency Room
- Federal and State Bureau of Prisons
- Federal Government
- Federally Qualified Health Center (FQHC) or look-alike
- Hospice
- Hospital
- Indian Health Service (IHS) Site
- Local Government Office or Agency (not LHD)
- Local Health Department (LHD)
- Local Correctional Facility
- Long-Term Care Facility
- Mobile Clinic/Site
- Nurse Managed Health Clinic
- Nursing Home
- Physician Office (Group or individual private practice)
- Physician Office (Hospital owned)
- Residential Living Facility
- School-based Clinic (Primary, middle, high school)
- Specialty Clinic (e.g. mental health practice/rehabilitation/substance abuse clinic)
- State Government Office or Agency (not MDH)
- State Health Department or Facility (MDH)
- Veterans Affairs Hospital or Clinic

6. Employer Name

7. Practice Site Name

Practice Site Address

Address Line 1

City

State

Zip Code

8. Are you completing this form for more than one practice site for this applicant?

Yes No

9. How many hours per week will the MLRP applicant work, excluding time spent "on call," as verified by the employment contract or offer?

Hours per week

10. Will the MLRP applicant work at least 80% of program participation hours per week in direct patient care?

Yes No

11. Will the MLRP applicant's work week be compressed into less than 4 days per week or with shifts of more than 12 hours in any 24-hour period, or into less than 2 days per week for an applicant working 20-39 hours per week?

Yes No

12. Will the MLRP applicant spend at least 45 weeks out of the year working during the time period July 1, 2024 - June 30, 2026 (with no more than 7 weeks away from the practice for holidays, vacation, continuing professional education, illness or any other reason)?

Yes No

13. What type of services is the MLRP applicant providing?

Outpatient Inpatient Outpatient and Inpatient

For employers of applicants applying in final year of medical residency:

14. To the best of my knowledge, the applying medical resident is enrolled full-time as a medical resident specializing in primary care.

Yes No

Please upload the following documents.

Practice Site Eligibility Form (Part III)

Template available at: <https://health.maryland.gov/pophealth/Pages/State-Loan-Repayment-Program.aspx>.

Complete and submit this form for all practice sites listed above.

Cultural Competency Requirements (Part IV)

Template available at: <https://health.maryland.gov/pophealth/Pages/State-Loan-Repayment-Program.aspx>.

Form only requires employer signature at this time. Applicant has provided a copy with their signature as required.

Experience, Impact, and Retention Data Requirements (Part V)

Template available at: <https://health.maryland.gov/pophealth/Pages/State-Loan-Repayment-Program.aspx>.

Form only requires employer signature at this time. Applicant has provided a copy with their signature as required.

Background Information about the Practice Site (e.g., practice brochure or marketing materials)

Practice's Non-Profit Certification (if applicable)

Practice's Sliding Fee Scale and Sliding Fee Scale Policy

Copy/Image of Public Notice at Practice Site Indicating Sliding Fee Schedule is in Effect

Applicant's Employment Contract or Other Verification of Applicant's Hours Worked per Week (if not contract employee)

(e.g. employment offer letter, Human Resources report, or other verification of hours worked per week).

16. The signatory of this form will be noted as the Administrator for the practice site for the purpose of receiving requests related to Part V (Experience, Impact, and Retention Data) of this application.

Name of the Person Completing this Form

Title

First

Last

Email Address

I attest that all of the information in this application is true and representative of the work to be conducted by the applicant named above. I am authorized to sign on behalf of the employer and practice site noted.

Signature

SAMPLE - NOT FOR SUBMISSION