South Carolina AHEC Program Office
Medical University of South Carolina
1 South Park Circle
Suite 203
Charleston, SC 29407

Marlboro County General Hospital Loan Repayment Incentives

Using funds from the Marlboro County General Hospital Foundation, South Carolina AHEC will provide loan repayment to medical practitioners (physicians, advanced clinical practitioners, pharmacists, and registered nurses) who practice in Marlboro County, South Carolina.

The purpose of the payments will be to attract medical practitioners to Marlboro County. Amounts will be determined by fund availability and will be set by South Carolina AHEC from time to time. The present policy is that physicians will be paid up to $25,000 for each year of service in Marlboro County, advanced clinical practitioners up to $15,000 per year, pharmacists up to $15,000 per year, and registered nurses up to $10,000. Contracts will be for a four-year period. Payments will be made annually the 13th month following 12 months of continuous full-time employment.

ELIGIBILITY:

The criteria for eligibility are as follows:

a. That the practitioner be a South Carolina licensed physician, advanced clinical practitioner, pharmacist or registered nurse.
b. That the practitioner practice half time or full time in Marlboro County, South Carolina.
c. That the practitioner has student loan debt.

Specific criteria for selection include all of the above eligibility criteria and the availability of funds.

INSTRUCTIONS:

Complete the following application and return to Kristin Cochran at cochrak@musc.edu .

An email will be sent to each applicant confirming the application is complete. If an email isn't received within three business days, please email the South Carolina AHEC office at cochrak@musc.edu to confirm receipt.

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Marlboro County General Hospital Foundation Loan Repayment Application

INSTRUCTIONS: Complete this application to receive consideration for the Marlboro County General Hospital Foundation Loan Repayment Program administered through the South Carolina AHEC. The following documentation must be submitted with the application: a curriculum vitae, a community letter of support from a lay member of the community, and copies of all educational loan documents. Your application must also include a copy of the SLED State Criminal Records Check and a completed National Practitioner Data Bank Self Query. The SLED check is accessible at South Carolina Law Enforcement Division (sc.gov) and the self query is accessible at http://www.npdb.hrsa.gov. There is a minimal charge for these background checks.

An email will be sent to each applicant confirming the application packet is complete. If an email isn't received within three business days, please email the South Carolina AHEC office at cochrak@musc.edu to confirm receipt.

I. Personal Information

1. Name _____ (Last) _____ (First) _____ (MI)

2. Current Home Address _____ (Address)

_____ (City) _____ (State) _____ (Zip)

3. Home Telephone _____ (With Area Code)

4. Current Work Address _____ (Business Name)

_____ (Address)

_____ (City) _____ (State) _____ (Zip)

5. Work Telephone _____ (With Area Code)

6. Email Address _____

7. Are you a U.S. citizen? (Yes/No) _____

8. Are you a SC resident? (Yes/No) _____

9. Are you Hispanic/Latino? (Yes/No) _____

10. Race (Please check all that apply)

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other

11. Total Educational Indebtedness $ _____

12. Have you previously applied for funding through the South Carolina Rural Physician Program (Incentive Grant or Loan Repayment)? (Yes/No) _____ Were you funded? (Yes/No) ____

II. Professional Background

1. Medical School/Health Professions Program _____

   Date of Graduation (Month/Year) _____

   Is the health professions program an online program? (Yes/No) _____

   If yes, please indicate the state where the majority of clinical training was completed. _____

   Were you a South Carolina AHEC Institute for Primary Care Education and Practice fellow during your health professions training? (Yes/No) _____

2. Clinical Specialty
   - ☐ Family Practice
   - ☐ Internal Medicine
   - ☐ Internal Medicine/Pediatrics
   - ☐ Ob/Gyn
   - ☐ Pediatrics
   - ☐ General Surgery
   - ☐ Psychiatry
   - ☐ Other If other, please list. _____

3. Practitioner Type
   - ☐ Nurse Midwife
   - ☐ Nurse Practitioner
   - ☐ Pharmacist
   - ☐ Physician
   - ☐ Physician Assistant
   - ☐ Registered Nurse

4. Current Training Status
- ☐ Nursing Student
- ☐ Advanced Practice Student
- ☐ Pharmacy Student
- ☐ Resident
- ☐ Fellow
- ☐ Training Complete

5. Most Recent Residency Program/Fellowship Completed _____
Name of Residency Program/Fellowship

_____ _____ _____ _____
Primary Street Address of Program City State Zip

6. Date you will complete/completed residency program (Month/Year) _____

7. Have you completed a Rural Residency Training Track? (Yes/No) _____

8. Additional Residency/Fellowship Training _____
Name of Residency Program/Fellowship

_____ _____ _____ _____
Primary Street Address of Program City State Zip

9. Date you completed additional residency/fellowship training (Month/Year) _____

10. Are you Board/Professionally Certified? (Yes/No) _____

What Clinical Area(s)?_____Date of Certification _____
Month/Year

11. If you are not Board Certified, do you expect to receive board certification within a year? (Yes/No) _____

12. South Carolina Licensing Agency_____South Carolina License Number_____

III. Other Sources of Funding

1. Did you incur a service obligation with any state, government, or other entity while obtaining your medical/health professions degree? (Yes/No) _____

If yes, please describe the type of obligation, including the starting and ending dates.

_____

_____

2. Have you received or will you be receiving any other loan repayment or practice incentives from state, federal or private sources? Note: The National Health Service Corps (NHSC) doesn't allow recipients to receive funding from both the NHSC and the Rural Physician Program at the same time. (Yes/No) _____

If yes, please provide the source, amount and duration of these funds.

_____

_____

IV. Loan Repayment Practice Location(s)

Please indicate your intended practice location(s) in Marlboro County for purposes of loan repayment funding.

Primary Practice Location Information

1. Primary Practice Location

_____

Name of Practice

_____ _____ _____ _____

Street Address of Practice City State Zip

2. Practice County Marlboro

3. Practice Type (Please check one) ☐ Community Health Center

☐ Federally Qualified Health Center

☐ Group Practice

☐ Rural Health Center

☐ Solo Practice

☐ Other If other, please list. _____

4. How many hours per week do you expect to serve at this location? _____

5. How long have you been in clinical practice at the above location? _____

6. If not yet in practice at the above location, when will you begin clinical practice at this location? _____

Secondary Practice Location Information (If Applicable)

7. Secondary Practice Location

_____

Name of Practice

_____ _____ _____ _____

Street Address of Practice City State Zip

8. Practice County_____

9. Practice Type (Please check one) ☐ Community Health Center

☐ Federally Qualified Health Center

☐ Group Practice

☐ Rural Health Center

☐ Solo Practice

☐ Other If other, please list. _____

10. How many hours per week do you expect to serve at this location? _____

11. How long have you been in clinical practice at the above location? _____

12. If not yet in practice at the above location, when will you begin clinical practice at this location? _____

V. Applicant Background Information

1. Date of Birth _____

2. Place of Birth _____ _____
City State

3. Did you live in a rural area/small town between the ages of 12-18? (Yes/No) _____

If yes, please provide the city and state.

_____ _____
City State

4. Home Prior to College _____ _____
City State

5. High School at Time of Graduation _____
Name

_____ _____
City State

6. College or University at Time of Graduation _____
Name

_____ _____
City State

7. Spouse/Partner's Place of Birth

_____ _____
City State

8. Did your spouse/partner live in a rural area/small town between the ages of 12-18? (Yes/No) _____

If yes, please provide the city and state.

_____ _____
City State

9. Spouse/Partner's Home Prior to College _____ _____
City State

10. Spouse/Partner's College or University at Time of Graduation _____
Name

_____ _____
City State

11. Do you or your spouse/partner have relatives currently practicing primary care medicine in rural South Carolina? (Yes/No) _____

If yes, please provide the county/counties?

_____

12. What, if any, personal connection do you have to the community where you will be practicing?

_____

_____

_____

13. Are you fluent in a language other than English? If so, please list._____

14. Have you ever served as a preceptor for health professions students? (Yes/No) _____

If yes, please provide the disciplines. _____

I understand that application to this program indicates a desire to commit to practice in Marlboro County in South Carolina for a period of time contingent upon amount of support I receive.

_____ _____

Name Date

Please submit the completed application packet to Kristin Cochran at cochrak@musc.edu.