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 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 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 or registered nurse.

b. That the practitioner practice 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.
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 www.sled.state.sc.us, 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

<p>| | | | | | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Current Home Address</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Home Telephone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Current Work Address</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Work Telephone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Email Address</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Are you a U.S. citizen? (Yes/No)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Are you a SC resident? (Yes/No)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Are you Hispanic/Latino? (Yes/No)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Race (Please check all that apply)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Total Educational Indebtedness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 □
   Physician □
   Physician Assistant □
   Registered Nurse □

4. Current Training Status

   Nursing Student □
   Advanced Practice 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

   ________________________________  City  State  Zip
   Street Address of Practice

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 City    State

   Name

6. College or University at Time of Graduation City    State

   Name

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 or fax to 843-792-4430