



**OKLAHOMA**  
State Department  
of Health

**CERTIFICATION OF  
SCHOOL LOAN**  
OKLAHOMA DENTAL LOAN REPAYMENT PROGRAM

Oklahoma State Dept. of Health  
Dental Health Service  
123 Robert S Kerr Ave, Ste 1702  
Oklahoma City, OK 73102  
405-426-8460  
ODLRP@health.ok.gov

Applicant Information

\_\_\_\_\_

Last Name	First Name	MI
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(COPY THIS PAGE IF NECESSARY TO LIST ADDITIONAL EDUCATIONAL DEBT) **If you have more than one educational loan with a particular lender, please total the amount of loans with that lender and record a combined figure.**

Lending Institution: \_\_\_\_\_

Account Number: \_\_\_\_\_

Month and Year loan repayment started/will start: \_\_\_\_\_

\$ _____	_____	_____
Current Outstanding Balance	Monthly Due Date	Monthly Payment

Lending Institution: \_\_\_\_\_

Account number: \_\_\_\_\_

Month and Year loan repayment started/will start: \_\_\_\_\_

\$ _____	_____	_____
Current Outstanding Balance	Monthly Due Date	Monthly Payment

Lending Institution: \_\_\_\_\_

Account number: \_\_\_\_\_

Month and Year loan repayment started/will start: \_\_\_\_\_

\$ _____	_____	_____
Current Outstanding Balance	Monthly Due Date	Monthly Payment



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**LENDER VERIFICATION**  
(TO BE COMPLETED BY EACH LENDER)  
Please copy additional forms if necessary.  
OKLAHOMA DENTAL LOAN REPAYMENT PROGRAM

Oklahoma State Dept. of Health  
Dental Health Service  
123 Robert S Kerr Ave, Ste 1702  
Oklahoma City, OK 73102  
405-426-8460  
ODLRP@health.ok.gov

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I authorize my lender, \_\_\_\_\_, to provide the loan information requested by the Oklahoma Dental Loan Repayment Program.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

**This section to be completed by the lending institution. Please type or print in black or blue ink.**

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Account Number

\_\_\_\_\_  
Outstanding Principle

\_\_\_\_\_  
Outstanding Interest

**Monthly payment information is necessary although a loan may be in deferment at the present time. If a repayment schedule has not yet been determined, please provide an estimate of the monthly payment.**

Is this loan for dental school education expenses, only?                      Yes                      No

Please indicate payment schedule:                      Monthly                      Quarterly

This loan is:                      Current                      In Default                      In Deferment

Has this loan ever been in default?                      Yes                      No

\_\_\_\_\_  
Name of Lender to Whom Payments will be Made

\_\_\_\_\_  
Printed Name of Official

\_\_\_\_\_  
Federal ID Number of Lender

\_\_\_\_\_  
Title of Official

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature of Official

\_\_\_\_\_  
City                      State                      Zip

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

Please return this form to:

**OKLAHOMA STATE DEPARTMENT OF HEALTH  
OKLAHOMA DENTAL LOAN REPAYMENT PROGRAM  
DENTAL HEALTH SERVICE  
123 ROBERT S KERR AVE, STE 1702  
OKLAHOMA CITY, OK 73102  
OR  
ODLRP@health.ok.gov**