APPLICATION

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

Applying for: ☐ Non-faculty (individual, group, or public health practice)

☐ University of Oklahoma College of Dentistry Faculty

SECTION A: APPLICANT INFORMATION

1. _____
   Last Name First Name MI

2. Previous name under which records may have been kept:_____

3. Social Security Number _____

4. Home Address:

   _____
   Number and Street Address City State Zip

   _____
   County in which you reside

5. Birth Date: _____ Gender: ☐ Male ☐ Female

6. Telephone: _(____)_____ _(____)_____
   Home Cell
   _(____)_____
   Work

7. Email Address: _____

8. Are you an Oklahoma resident? ☐ Yes ☐ No

9. Have you ever been convicted of a felony? ☐ Yes ☐ No

   If YES, explain.

10. Have you ever been disciplined, suspended, or dismissed by administrative, military, or other authorities? ☐ Yes ☐ No

    If YES, explain.

11. Are you an American Dental Association recognized specialist? ☐ Yes ☐ No

If YES, what specialty? _____

12. Do you have hospital or operating room privileges? ☐ Yes ☐ No

If YES, where? _____

13. Do you speak a language in addition to English? ☐ Yes ☐ No

If YES, what language(s)? _____

SECTION B: Dental School Information

_____
Name of Dental School

_____
Address

_____
City State Zip

Date of Graduation: _____ Degree Earned: _____
Must submit proof of graduation as per APPLICATION GUIDELINES, Application Process.

Awards/Fellowships/Certificates Earned: _____

SECTION C: DENTAL LICENSING INFORMATION

Do you have an Oklahoma dental license? ☐ Yes ☐ No

If yes, license number _____
(Must submit proof of licensure as per APPLICATION GUIDELINES, Application Process.)

If no, have you passed the required exams and are you eligible for an Oklahoma license?

☐ Yes ☐ No

If no, do you have an application pending with the State of Oklahoma? ☐ Yes ☐ No

State(s) of current unrestricted licensure: _____

Has your dental license ever been revoked or suspended? ☐ Yes ☐ No

If YES, please give reason for revocation or suspension of license.

SECTION D: MEDICAID PROVIDER INFORMATION (REQUIRED FOR NON-FACULTY POSITIONS, ONLY.)

☐ I have/will have fulfilled the requirements of the Oklahoma Health Care Authority for a Medicaid Dental Provider at the time this service obligation begins, if accepted into the ODLRP.

Medicaid Provider Number: _____

SECTION E: PRIOR EMPLOYMENT/VOLUNTEER INFORMATION (PLEASE LIST ONLY RELEVANT POSITIONS.)

1. _____(____)_____
   Name of Employer/Organization Telephone

   _____
   Address

   _____
   City State Zip

   Position: _____

   Period of Service: From_____ To_____

2. _____(____)_____
   Name of Employer/Organization Telephone

   _____
   Address

   _____
   City State Zip

   Position: _____

   Period of Service: From_____ To_____

SECTION F: EDUCATIONAL ASSISTANCE HISTORY

1. Have you applied for any other loan assistance repayment programs? ☐ Yes ☐ No

   If YES, please name the program and describe the service agreement.

2. a) Have you **EVER** defaulted on an educational loan? ☐ Yes ☐ No

   If YES, please explain.

   b) Are you **CURRENTLY** in default on an educational loan? ☐ Yes ☐ No

   If YES, please explain.

3. Are you currently serving an obligation(s) to any other entity for loan repayment or scholarships? ☐ Yes ☐ No

   If YES, please describe.

4. Have you ever breached any service obligation(s), contract(s), etc.? ☐ Yes ☐ No If YES, please explain.

SECTION G: PERSONAL STATEMENT

Please provide a statement that briefly explains why you are applying to the Oklahoma Dental Loan Repayment Program, and any additional information you think might be relevant to the selection process.

SECTION H: CERTIFICATION

All the information on this application is true to the best of my knowledge. If requested by the Oklahoma State Department of Health, I will provide proof of the information I have given on this application.

Acceptance by the Department of this application does not obligate the Department to anything other than the review of the application.

I give permission for any information related to my ODLRP application to be verified by the Department and shared with the members of the ODLRP Advisory Committee as part of the review process in consideration for the ODLRP award.

Applicant Signature Date

CHECKLIST

Applicants must submit the following items to complete the application process. No application will be reviewed until all materials listed below have been received.

Please check that the following items are included in your application.

Forms to be submitted to the Oklahoma State Department of Health by the applicant:

☐ Completed Application, *ODH Form 323*

☐ Completed Practice Site Confirmation, *ODH Form 323B*, for each designated site. Include applicable document from one of the following.

- Signed Non-Faculty Applicant Employer Agreement, *ODH Form 323C*, from the owners/employers of the dental practice(s), if employed by a group practice or public health clinic (enclose for each practice location).
- Copy of most recent business tax return if individual (solo) practice.
- Signed Faculty Applicant OU College of Dentistry Agreement, *ODH Form 323D*.

☐ Completed Certification of School Loan, *ODH Form 323E*.

☐ Proof of graduation from an accredited U.S. dental school (an official academic transcript, an official letter from the school showing the degree earned and the date of graduation, or a copy of diploma will be accepted).

☐ Proof of an Oklahoma Dental License/Faculty Permit (a copy of the license or the certification of paid annual registration fee, or an official letter from the Oklahoma Board of Dentistry).

Forms to be submitted directly to the Oklahoma State Department of Health by applicable parties.

☐ Completed Lender Verification, *ODH Form 323F*, from each lending institution.

☐ Letters of Recommendation, *ODH Form 323G*, from three (3) professional or educational references (do not include recommendations from relatives or employees).

It is the applicant's responsibility to ensure that <u>all</u> forms are completed and returned to the Oklahoma State Department of Health.

PLEASE RETURN THE COMPLETE APPLICATION 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