

**UNIVERSITY OF MASSACHUSETTS CHAN MEDICAL SCHOOL LEARNING CONTRACT
ANNUAL REQUEST FOR POSTPONEMENT OF REPAYMENT DUE TO SERVICE PAYBACK—UNDER SERVED**

PART 1 - GENERAL INFORMATION (to be completed by borrower - please type or print)

NAME OF BORROWER _____

SOCIAL SECURITY NUMBER _____

NAME USED AT UMMS _____

CLASS YEAR or SEPARATION DATE FROM UMMS _____

STREET ADDRESS _____

(_____) _____
HOME TELEPHONE NUMBER

CITY _____ STATE _____ ZIP CODE _____

(_____) _____
WORK TELEPHONE NUMBER

Email address: _____

PART 2 - POSTPONEMENT REQUEST INFORMATION

Because I expect to pay my learning contract with service, I request postponement of payment while I practice for 12 consecutive months within the Commonwealth of Massachusetts. I declare that I am currently engaged in the practice of health care in a manner consistent within my medical education & training as a physician.

A. Requested postponement dates: from: ____/____/____ to: ____/____/____ ***A single form cannot be certified for more than ONE (1 year in advance).**

B. Place of Employment: _____

C. I certify that I am/was engaged in the following practice of health care in a manner consistent within my medical education and training as a PHYSICIAN in:

1) _____ **UNDER SERVED (MUST BE PRE-APPROVED BY UMMS)**

D. In addition to my postponement form, I have attached an original Job Description (please see page 3 for details), and I have attached a letter explaining the underserved population that I am serving, and I have attached documentation that demonstrates the payer mix at employment site.

*I must complete this form **annually** while I perform eligible employment (as specified in contract.) If I change jobs within the 12 months requested, I must complete another postponement form for the new site, and a cancellation form from your prior site. I also understand and agree that if for any reason I do not complete the entire period of service listed above, I will notify UMMS and begin monetary payments immediately. Please contact the financial aid office for further instructions.*

SIGNATURE OF BORROWER

DATE



PART 3

TIMELINE OF ACTIVITIES SINCE GRADUATION FROM MEDICAL SCHOOL

Please provide a **chronological listing by month and year of ALL activities since graduation from medical school.** You must include postgraduate training, research activities, hospital affiliations, medical staff appointments, faculty appointments, private practices, locum tenens and telemedicine assignments and any other employment or volunteer activities. Also include periods of unemployment or any activities outside of the practice of medicine. Do not write, "See CV" or "See attached"; you must complete this section AND attach your

curriculum vitae. If you need additional rows, please print additional copies of this page. **You MUST account for any time gaps of one month (30 days) or more since your graduation from medical school.** (For example, if you graduated from residency in June 2015 and started employment in August 2015, you must account for this gap.)

Start Date (mm/yyyy)	End Date (mm/yyyy)	Position Held (Resident, Attending, Research Fellow, etc.)	Institution/Place of Employment	City, State, Zip & County
_____ Month Year		Medical School Graduation Date (start timeline from this date)		

PART 4 - CERTIFICATION BY A THIRD PARTY AUTHORIZED BY SERVICE SITE (Program Director, Supervisor, Business Manager, or Equivalent)

NAME OF EMPLOYER	DEPARTMENT/PROGRAM
ADDRESS	CITY/STATE/ZIP
TELEPHONE NUMBER	COUNTY
DATE EMPLOYEE BEGAN PRACTICING MEDICINE AT CURRENT SITE:	_____
TITLE OF EMPLOYEE POSITION:	_____
EMPLOYEE FTE PERCENTAGE:	_____
INDICATE THE NUMBER OF CLINICAL HOURS PER WEEK:	_____
INDICATE THE NUMBER OF ADMINISTRATIVE HOURS PER WEEK:	_____
IS THIS POSITION CONSIDERED A HOSPITALIST:	YES _____ NO _____

I certify that the information for the person named above, including dates and service type are true and correct, and service was completed in Massachusetts.

SIGNATURE	PRINTED NAME	TITLE	DATE
➔ (PROGRAM DIRECTOR, SUPERVISOR, BUSINESS MANAGER, or EQUIVALENT)			

**University of Massachusetts Chan Medical School Learning Contract
Request for Postponement of Service Payment**

INSTRUCTIONS

You may use this form to postpone the due date of payment on your Learning Contract if you are currently providing service that qualifies for payment.

*** * * THIS FORM MUST BE COMPLETED ON AN ANNUAL BASIS. * * ***

1. Applicant should complete Parts 1-3
2. Part 4 of the form should be certified by an authorized employer representative who clearly indicates his or her job title.

-or-

If you are self-employed, please provide documentation of hospital admitting privileges, or contact the Financial Aid Office for instructions

3. Submit Letter from the borrower explaining the underserved population he/she is servicing (a lot of times this is a letter to the committee of them asking to be considered for service payback, backed up with the population they are servicing).
4. Documentation to demonstrate the payer mix at employment site.
5. Return the original completed, signed and certified form along with an original **JOB DESCRIPTION LETTER*** to:

**Financial Aid Office
UMASS Chan Medical School
55 Lake Ave. North
Attn Tina Sasseville S1-416
Worcester, MA 01655**

*Job description letters must include the following information on letterhead from your employer: date began practicing medicine at current site, dates requesting postponement of service, FTE percentage, description of employment, and signature and title of authorized individual (human resources, business manager, supervisor or program director).

If you change jobs within the 12 months requested, you must complete another postponement for the new site, and a cancellation form from your prior site. Please contact the Loan Manager for further instructions.