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

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, AND **I have attached an original Job Description** (please see page 3 for details).

A. Requested postponement dates: from**:** _____**/**_____**/**_____ to**:** _____**/**_____**/**_____ ***A single form c****annot 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:

Please check 1, 2, and 3:

1)_____ PRIMARY CARE Type (A-E: See list on reverse.)

2)_____ PUBLIC SERVICE Type (A-J: See list on reverse.)

3)_____ COMMUNITY SERVICE Type (A-D: See list on reverse.)

D. In addition to my postponement form, **I have attached an original Job Description** (please see page 3 for details),

*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 Loan Manager 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 5 - 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. Return the original completed, signed and certified form along with an original **JOB DESCRIPTION*** to:

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

4. 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 FAO for further instructions.

*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.)

PHYSICIAN SERVICE TYPES
(All service must be performed in the Commonwealth of Massachusetts)

1) Primary Care Physician
- A. Family Medicine
- B. General Internal Medicine
- C. General Pediatrics
- D. Preventive Medicine
- E. Obstetrics and Gynecology

2) Public Service
- A. Municipal or County Hospital
- B. Correctional Facility
- C. Public Health Site (state or local)
- D. Medical Examiner (state or local)
- E. Veterans Administration
- F. Municipal or state owned facility; e.g., Soldiers Home or long term care facility
- G Other agencies of state government. This category requires pre-approval from UMMS
- H. State Mental Health Facility
- I. An agency that receives at least 50% of its funding from the Commonwealth or Medicaid program
- J. An agency located in a community with a disproportionate share of low-income citizens or an agency whose clients are primarily low-income **and** without medical insurance. This category requires pre-approval from UMMS.

3) Community Service
- A. Homeless Health Programs
- B. HIV/AIDS Organization
- C. Clinical specialty services at a Community Health Center
- D. Clinical specialty services at a non-governmental health and human services agency; e.g., Domestic Violence Programs, Child Abuse Programs, etc.