UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL LEARNING CONTRACT
REQUEST FOR *CANCELLATION* OF LEARNING CONTRACT

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

NAME OF BORROWER

175-02/04 _____-_____-_____
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

EMPLID

PART 2 – CERTIFICATION and Description of duties.

I declare that 1) I was engaged in the full-time practice of health care in a manner consistent with my medical education and training, as indicated below, the equivalent of 24 or 48 consecutive months (as specified in contract) within the Commonwealth of Massachusetts, and 2) I began qualified practice no later than 6 months following completion of internship, residency, or fellowship, whichever occurred latest. Activities required for residency do not qualify.

A. Place of Employment**:**_____

B. 1) Full time: _____ or **2)** Part-time _____if part-time, Number of hours worked per week?_____

C. Dates of employment: from**:** _____/_____/_____ to**:** _____/_____/_____

D. I certify that I 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, 3 or 4:

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.)

4)_____ UNDER-SERVED (Must be pre-approved by UMMS)

SIGNATURE OF BORROWER **DATE**
➔

PART 3-CERTIFICATION BY A THIRD PARTY AUTHORIZED BY SERVICE SITE (Program Director, Supervisor, Business Manager, or Equivalent)

I certify under the pains and penalties of perjury that this MD's declaration of service provided within the Commonwealth of Massachusetts, beginning and ending dates, and description of duties are true and correct.

INSTITUTION

DEPARTMENT/PROGRAM

ADDRESS

CITY/STATE/ZIP

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

PART 4 -UMMS USE ONLY

	FROM	**TO**	**NO. MONTHS**	**CODE**
POSTPONEMENT PERIOD	_____/_____	_____/_____	_____	_____
POSTPONEMENT PERIOD PREVIOUSLY APPROVED	_____/_____	_____/_____	_____	_____

FORMS PROCESSED BY: _____ DATE: ___ UAS NOTIFIED DATE: _____

University of Massachusetts Medical School Learning Contract
Request for Cancellation of Learning Contract

INSTRUCTIONS

1. Complete Part 1: General Information

2. Complete Part 2: Indicate employer, full- or part-time status, provide dates of the full term of service,* service type, sign, and date. *If you provided service at more than one site, you will need to complete a Cancellation Form for each site.

3. Complete Part 3: Have this certified by an authorized employer representative who clearly indicates his or her job title.

4. Return Completed, Signed and Certified form to:

Student Loan Manager
Financial Aid Office
UMASS Medical School
55 Lake Ave. North
Worcester, MA 01655

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 Program
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.

4. Underserved Area

All service provided under this category **requires pre-approval** by UMMS.