

4. LANGUAGE OTHER THAN ENGLISH _____

Read Write Speak (Fluently)

5. DO YOU HAVE AN EXISTING SERVICE OBLIGATION? Yes No

IF YES, NAME OF THE PROGRAM _____

ADDRESS OF THE PROGRAM _____

CONTACT PERSON _____

TELEPHONE NUMBER _____

TERMS OF THE OBLIGATION _____

ARE YOU IN DEFAULT OF THIS OBLIGATION? Yes No

WHEN WILL THE OBLIGATION BE COMPLETED? _____

6. WHEN WILL YOU BE AVAILABLE TO RELOCATE TO SAN MATEO COUNTY? _____

7. ARE THERE ANY PERSONAL CONSIDERATIONS THAT WOULD LIMIT YOUR ABILITY TO RELOCATE?
(i.e., spouse employment, health, family or personal preferences for specific communities)

YES NO

(If yes, please describe) _____

8. NAME OF PROFESSIONAL SCHOOL FROM WHICH YOU GRADUATED _____

Street City State Zip Code

9. YEAR OF GRADUATION: _____
YEAR

DEGREE OBTAINED: _____

10. HAVE YOU COMPLETED A RESIDENCY OR GRADUATE PROGRAM? YES NO

YEAR WHEN RESIDENCY OR PROGRAM WAS OR WILL BE COMPLETED _____

RESIDENCY OR PROGRAM NAME AND LOCATION _____

ADDRESS _____
Street City State Zip Code

INTERNSHIP PROGRAM? IF SO, DESCRIBE PROGRAM, LOCATION, AND DATES:

ARE YOU BOARD CERTIFIED OR BOARD ELIGIBLE (INDICATE) _____

YEAR RE-CERTIFIED IF APPLICABLE _____

DESCRIBE RESIDENCY OR PROGRAM TRAINING EXPERIENCE OUTSIDE THE TEACHING HOSPITAL OR PROFESSIONAL SCHOOL. (Include experience in working with shortage area populations, rotations in rural and urban areas, nature of the rotations, and length of the rotations.)*

- 11. CREDENTIALS (Required before beginning service): ARE YOU PRESENTLY HOLDING A LICENSE, REGISTRATION, AND/OR CERTIFICATION?**

Yes No

INDICATE STATE(S) _____

NOTE ANY LICENSURE RESTRICTIONS: _____

EXAMINATION(S) PASSED _____ **PLAN TO TAKE** _____ **STATE** _____
Month/Year Month/Year

State or Regional Board: _____

National Certification: _____

- 12. DESCRIBE YOUR PRACTICE EXPERIENCE SINCE COMPLETION OF YOUR TRAINING. (Location, nature of the population served, number of specialties in the practice, hospital affiliations, and allocation of clinical practice time to FP/GP, IM,OB/GYN, PED, PSYCH, ER)**

- 13. LIST NAME AND ADDRESS OF THE LAST SITE AT WHICH YOU WORKED AS A CLINICIAN.**

Street City State Zip Code

TELEPHONE NUMBER OF CLINICAL SITE / DIRECTOR OF SITE _____
Area Code / Number

- 14. PLEASE ATTACH CURRENT CURRICULUM VITAE**

- 15. PLEASE PROVIDE THREE (3) PROFESSIONAL REFERENCES (Confidential)**

Reference Name _____

Position or Title _____

Address _____

Telephone _____

Reference Name _____

Position or Title _____

Address _____

Telephone _____

Reference Name _____

Position or Title _____

Address _____

Telephone _____

16. **AMOUNT OF LOAN REQUESTED (UP TO MAXIMUM \$50,000):** _____

17. **CURRENT PROFESSIONAL LIABILITY COVERAGE INSURANCE CARRIER AND AMOUNT OF COVERAGE:**

CERTIFICATION

I certify that the information given in this application is accurate and complete to the best of my knowledge and belief.

I understand it may be investigated and that any false representation is sufficient cause for rejection of this application, or, if awarded a Loan, that I am liable for repayment of all awarded funds if this application proves false. I hereby authorize the release of any information flowing from sources of information identified in this Application about my professional background and experience.

SIGNATURE

DATE