PRIMARY CARE LOAN (PCL) PROGRAMS SELF-CERTIFICATION FORM FOR YEAR ____

As PCL recipient you are required to practice primary health care until your loan is repaid in full. Please complete and return this form to us in the enclosed envelope.

NAME

HOME ADDRESS

HOME PHONE NUMBER

WORK ADDRESS

WORK PHONE NUMBER

CURRENT PRACTICE STATUS

FAMILY MEDICINE

GENERAL INTERNAL MEDICINE

GENERAL PEDIATRICS

PREVENTIVE MEDICINE

OSTEOPATHIC GENERAL PRACTICE

GENERAL DENTISTRY

OTHER SPECIALTY

COMMENTS

I CERTIFY THAT THE INFORMATION CONTAINED ON THIS CERTIFICATION FORM IS ACCURATE AND THAT I AM IN COMPLIANCE WITH THE OBLIGATIONS SPECIFIED IN MY PRIMARY CARE LOAN PROMISSORY NOTE FOR PRIMARY CARE SERVICE.

SIGNATURE

DATE

RETURN COMPLETED FORM TO:

UCSF – Controller's Office
Attn: Student Accounts
1855 Folsom Street, MCB 425, Box 0815
San Francisco, CA 94143-0815

4/22/10 - el