



PRACTICE SITE CONFIRMATION

OKLAHOMA DENTAL LOAN REPAYMENT PROGRAM

Oklahoma State Dept. of Health
Dental Health Service
1000 N.E. Tenth Street
Oklahoma City, OK 73117-1299
405-271-5502
<http://den.health.ok.gov>

Applicant Information (Please type or print in black or blue ink.)

Last Name First Name MI

Provide information on the location(s) where you will be working if selected to participate in the Oklahoma Dental Loan Repayment Program (ODLRP). Non-faculty practice sites must be in a shortage area according to the Oklahoma Dental Health Professional Shortage Area policy. (Please copy and attach additional sheets as necessary.)

Practice Site Name Telephone

Address

City State Zip County

Is this a(n):

- | | |
|---|---|
| <input type="checkbox"/> Existing Individual (solo) Private Practice* | <input type="checkbox"/> University of Oklahoma |
| <input type="checkbox"/> Commitment to establish an Individual Private Practice | <input type="checkbox"/> College of Dentistry |
| <input type="checkbox"/> Group Private Practice** | (skip to Faculty Applicant |
| <input type="checkbox"/> Public Health Clinic** | OUCOD Agreement form) |

***If this is an Individual (solo) Private Practice, please provide a copy of the most recent business tax return.**

****If this is a Group Private Practice or Public Health Clinic, is the owner(s)/employer(s) willing to support you in this endeavor? Yes No**

If YES, please have the owner(s)/employer(s) complete the Non-Faculty Applicant Employer Agreement form.

Is this a new practice site for you? Yes No

If Yes, skip to next form. If No, continue this form.

How long have you been at this practice site? _____ Years _____ Months

How many hours a week do you treat patients at this practice site? _____ Hours

Please estimate your CURRENT (not anticipated) Oklahoma Medicaid recipient caseload (unduplicated count) _____%

Have you spent more than 224 hours per year away from the practice site for holidays, vacations, continuing professional education, illness, or any other reason during this period of employment? Yes No

If YES, please explain: _____



**NON-FACULTY APPLICANT
EMPLOYER AGREEMENT**
OKLAHOMA DENTAL LOAN REPAYMENT PROGRAM

Oklahoma State Dept. of Health
Dental Health Service
1000 N.E. Tenth Street
Oklahoma City, OK 73117-1299
405-271-5502
<http://den.health.ok.gov>

Applicant Information (Please type or print in black or blue ink.)

Last Name	First Name	MI
-----------	------------	----

The individual listed above is applying for the Oklahoma Dental Loan Repayment Program (ODLRP). This program is designed to increase the number of dentists serving and caring for those dependent upon the state for dental care. By agreeing to be part of this program, the applicant agrees that in return for school loan repayment assistance, a minimum of 30% of his/her patients will be Oklahoma Medicaid recipients at the time of treatment.

By signing this you are acknowledging that the individual listed above is permitted to use your dental practice site to meet this 30% goal. There will be some record keeping and reporting to ensure the individual is meeting his/her 30% goal. You also agree to have an ODLRP representative conduct a site visit(s), if necessary, to confirm that the practice site exists, explain how the program works, or perform other programmatic duties.

If you have any questions prior to signing this agreement, please e-mail Mrs. Susan Potter, Program Manager, Oklahoma Dental Loan Repayment Program, Dental Health Service, Oklahoma State Department of Health, at ODLRP@health.ok.gov.

1. _____
Owner(s)/Employer(s) Signature Date

Print Name Title

2. _____
Owner(s)/Employer(s) Signature Date

Print Name Title

3. _____
Owner(s)/Employer(s) Signature Date

Print Name Title

Practice Address: _____

Telephone Number: _____



Oklahoma
State
Department
of Health

FACULTY APPLICANT OU COLLEGE OF DENTISTRY AGREEMENT

OKLAHOMA DENTAL LOAN REPAYMENT PROGRAM

Oklahoma State Dept. of Health
Dental Health Service
1000 N.E. Tenth Street
Oklahoma City, OK 73117-1299
405-271-5502
<http://den.health.ok.gov>

Applicant Information (Please type or print in black or blue ink.)

Last Name

First Name

MI

The individual listed above is applying for the Oklahoma Dental Loan Repayment Program (ODLRP). This program is designed to provide an opportunity to staff faculty positions at the University of Oklahoma College of Dentistry. By agreeing to be part of this program, the individual listed above agrees that in return for school loan repayment assistance, he/she will accept and abide by the rules and regulations of a faculty member and the job duties assigned by the Dean of the University of Oklahoma College of Dentistry.

By signing this you are agreeing to employ this individual, if accepted into the ODLRP, as a faculty member. There will be some minimal record submission to ensure the individual is fulfilling his/her duties as a faculty member.

If you have any questions prior to signing this agreement, please e-mail Mrs. Susan Potter, Program Manager, Oklahoma Dental Loan Repayment Program, Dental Health Service, Oklahoma State Department of Health, at ODLRP@health.ok.gov.

Signature of Dean

Date

Print Name

Telephone Number